Exhibit 3

Part 1

Georgia

UNIFORM APPLICATION
FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 12/03/2020 3.29.41 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 965736635

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Georgia Department of Behavioral Health and Developmental Disabilities

Organizational Unit Division of Behavioral Health

Mailing Address 2 Peachtree Street, 24-290

City Atlanta

Zip Code 30303

II. Contact Person for the Grantee of the Block Grant

First Name Judy

Last Name Fitzgerald

Agency Name Department of Behavioral Health and Developmental Disabilities

Mailing Address 2 Peachtree Street 24-290

City Atlanta

Zip Code 30303

Telephone 404-463-7946

Fax 770-408-5480

Email Address judy.fitzgerald@dbhdd.ga.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ☐ Yes ☐ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/3/2019 9:21:47 PM

Revision Date 12/3/2020 3:28:59 PM

VI. Contact Person Responsible for Application Submission

First Name Jill

Last Name Mays

Telephone 404-657-5681

Fax

Email Address jill.mays@dbhdd.ga.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Judy Fitzgerald

Signature of CEO or Designee [1]: _____

Title: Commissioner

Date Signed: _____

mm/dd/yyyy

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Brian P. Kemp
GOVERNOR

August 19, 2019

Ms. Odessa Crocker
Grants Management Officer
Office of Financial Resources,
Division of Grants Management
Substance Abuse and Mental
Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland *20857*

Re: The Community Mental Health Services Block Grant (MHBG) and
The Substance Abuse Prevention and Treatment Block Grant (SABG)

Dear Ms. Crocker:

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), specifically the Division of Behavioral Health, is currently identified as the Single State Authority for community mental health and substance use services. As the Governor of the State of Georgia, for the duration of my tenure, I delegate authority to the current Commissioner of DBHDD, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG).

On behalf of the citizens of the State of Georgia, I thank you for the opportunity to continue our participation in this grant program.

Sincerely,

Brian P. Kemp

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

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Substance Abuse and Mental Health Services Administrations
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

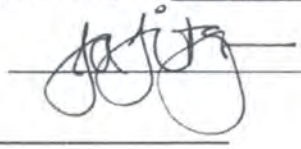
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Judy Fitzgerald

Signature of CEO or Designee[1]: 

Title: Commissioner

Date Signed: 08.29.2019

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Georgia Department of Behavioral Health
& Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D

Division of Behavioral Health

November 5, 2019

Tiffany Pham
Grants Management Officer
Division of Grants Management
Department of Health and Human Services
SAMHSA

Wendy Pang
Grants Management Officer
Division of Grants Management
Department of Health and Human Services
SAMHSA

Re: Marijuana Attestation for Georgia Mental Health Grants

- Block Grant for Community Mental Health Services (**Grant Number: 3B09SM010061-19S3**)
- Georgia AIME SOC Grant (**Grant Number: 6H79SM080153-02M001**)
- PATH Grant (**Grant Number: 6X06SM016058-19M001**)

Dear Grants Management Officer:

As per the Terms and Conditions stated in the revised NoAs, dated October 10, 2019, I certify that the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and all sub-recipients of the above stated grant programs will comply with the following NoA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

DBHDD remains committed to the goals of our SAMHSA grant programs and to providing easy access to high-quality care that leads to a life of recovery and independence for the people we serve.

Sincerely,

Judy Fitzgerald, Commissioner
Department of Behavioral Health and Developmental Disabilities

CC: Monica Johnson, Director, Division of Behavioral Health, DBHDD

Jill Mays, Director, Office of Federal Grant Programs & Cultural and Linguistic Competency, DBHDD
Letitia Robinson, State PATH Contact, Assistant Director, Office of Supported Housing, DBHDD
Dante McKay, Director, Office of Children, Young Adults, and Families, DBHDD
Matthew Clay, AIME Program Director, Office of CYF, DBHDD

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

N/A

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE OVERVIEW

THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

Created by the Governor and General Assembly in 2009, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and its network of community providers offer treatment and support services to help people with behavioral health challenges achieve recovery by focusing on their strengths. Through uniquely tailored supports and services, the department also helps people with intellectual and developmental disabilities attain independence and lead meaningful and fulfilling lives. DBHDD's vision is "Easy access to high-quality care that leads to a life of recovery and independence for the people we serve". The mission is "To lead an accountable and effective continuum of care to support people with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment.
As a Cabinet-level department, DBHDD is the state agency responsible for administration, coordination, planning, regulation and monitoring of all components of the state public behavioral health and intellectual and developmental disability systems. DBHDD operates state hospitals and provides for community-based services across the state through contracted providers. As Georgia's public safety net, the department's primary responsibility is to serve people who are uninsured. Individuals on Medicaid and others with few resources or options are also served.

DBHDD Commissioner

Judy Fitzgerald was appointed Commissioner of DBHDD in December 2016, and reports directly to the Governor of the State of Georgia. Commissioner Fitzgerald, who is a social worker with a career-long focus on behavioral health and public health delivery systems, has been with DBHDD since 2012, previously serving in the roles of Chief of Staff and Deputy Commissioner.

DBHDD Board of Directors

The Board of Georgia DBHDD establishes the general policy to be followed by the department. The nine-member Board of Directors is appointed by the Governor and confirmed by the Senate. Each member of the board is appointed for a term of three years following initial appointments of staggered terms as provided by the state statute.

Behavioral Health Coordinating Council

DBHDD is also advised by a Behavioral Health Coordinating Council (BHCC), which is administratively attached to DBHDD. The Council members include the Commissioners of the Departments of Corrections, Human Services, Juvenile Justice, Labor, Public Health, Community Affairs (Housing) and Community Health (Medicaid authority); the State Superintendent of Education; the Chairperson of the State Board of Pardons and Paroles; one

Senator, one Representative, one family member of a consumer, one parent representative and one adult consumer. The Council is led by an executive committee comprised of a chairperson, vice-chairperson, secretary and two other members. The Commissioner of Behavioral Health and Developmental Disabilities serves as the Chairperson of the Council.

The purpose and mission of the BHCC is to identify overlapping services regarding funding and policy issues in the behavioral health system. The BHCC is specifically tasked with developing solutions to the systemic barriers or problems to the delivery of behavioral health services by making recommendations that implement funding, policy changes, practice changes, and evaluation of specific goals designed to improve services delivery and outcome for individuals served by the various departments; focusing on specific goals designed to resolve issues for provision of behavioral health services that negatively impact individuals serviced by at least two departments; monitoring and evaluating the implementation of established goals; and establishing common outcome measures. The BHCC has regularly consulted with various stakeholders around the state to understand the realities, needs and resources of/for individuals living with behavioral health challenges. The BHCC since its inception has considered and discussed a range of issues including transportation, children and adolescents, sharing of health information, housing, funding, partnerships, and workforce development. In addition, there are two BHCC sub-committee's which serve at the discretion of the Executive Committee and BHCC; one on children and youth services, the Interagency Director's Team (IDT), and one that focuses on the transition of individuals with behavioral challenges from the criminal justice system back into the community, that is the Transition Re-entry Committee.

Commissioner's Executive Leadership Team

Guided by its vision and mission, the Department has reshaped its organizational structure to create a centrally-managed model that is aligned by function. DBHDD's vision is "Easy access to high-quality care that leads to a life of recovery and independence for the people we serve". The mission is "To lead an accountable and effective continuum of care to support people with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment." DBHDD is organized through the Commissioner's Executive Leadership team which consists of several Office and Division Directors. This includes the Commissioner, Deputy Commissioner/Chief Operating Officer, Assistant Commissioner/General Counsel, Director of the Division of Hospital Services/Chief Medical Officer and Directors of the Office of Public Affairs, Division of Developmental Disabilities, Office of Hospital Operations, Special Projects, Division of Behavioral Health, Division of Accountability and Compliance, Division of Performance Management and Quality Improvement, Office of Budget and Finance, Office of Human Resources and Learning, and Office of Information Technology.

Three of the Divisions mentioned above were created during the restructuring: Division of Accountability and Compliance, Division of Performance Management and Quality

Improvement and the Division of Behavioral Health, all pertinent to the successful operation of behavioral health services. The Division of Accountability and Compliance is responsible for the monitoring and testing of compliance with contractual, regulatory, and health and safety standards; and, conducts coordinated reviews including provider audits, incident investigations and follow-up reviews. The Division of Performance Management and Quality Improvement (PMQI) is responsible for utilizing data, trends, and system knowledge to systematically and consistently manage a network of providers and promote improvements in performance and quality of services. PMQI achieves this via several functions: Coordination and management of the administrative services organization; Utilization of research methods, program measurement and evaluation to analyze data; Development and implementation of an integrated quality framework, quality monitoring, and related initiatives; Consolidated office of provider network management; and, Coordination with Medicaid/DCH and other external partners to support health systems innovation. The third Division, Division of Behavioral Health, is described in the next section.

The Division of Behavioral Health

The **Division of Behavioral Health (DBH)** is overseen by Monica Johnson, MA, LPC, who reports directly to the Commissioner of DBHDD and is responsible for providing leadership for all behavioral health services for children and adolescents, emerging adults and adults. There are 9 offices within this Division: Adult Mental Health (OAMH); Children, Young Adults and Families (OCYF); Addictive Diseases (OAD); Behavioral Health Prevention (OBHP); Deaf Services (ODS); Recovery Transformation (ORT); Field Operations; Crisis Services; and Federal Grant Programs and Cultural and Linguistic Competency (OFGP/CLC). DBH is the authority for behavioral health programs, services and supports statewide. The primary areas of focus are policy and planning; program development; budget management and spending plan development, workforce development; and, collaboration with stakeholders. Some of the key responsibilities are:

- Guide statewide clinical best practices
- Develop service guidelines
- Identify and develop standards, policies and key performance indicators
- Identify and implement short and long-term programmatic improvement initiatives
- Develop strategic planning and implementation of services
- Serve as subject matter experts for external and internal stakeholders
- Provide technical assistance and training to ensure competency with the provider network

The Division's goal is to build a recovery-oriented, community-based system of care, with the capacity to provide timely access to high-quality behavioral health treatment and support services. Recovery accepts that severe and persistent mental illness, substance use, and co-occurring disorders are long-term conditions that a person will be managing for life. This model signifies a shift from crisis-driven services to a prevention-focused continuum of care that

provides sustained support, and is based on the strengths, wellness, and goals of the person in recovery. The division also supports policy development, service planning, program development, budget development, workforce development (training), and external collaboration with stakeholders across the system of care. The following information describes each of the Offices within DBH.

The **Office of Adult Mental Health (OAMH)** is led by the Director of OAMH. It is staffed with 19 staff: an Assistant Director responsible for traditional outpatient Core Services, , and Crisis Services; three staff responsible for mental health treatment/accountability courts, three staff responsible for oversight of Supported Employment including fidelity reviews and technical assistance; three staff responsible for oversight and fidelity monitoring for ACT and CST; one staff responsible for emergency preparedness and disaster planning; three staff responsible for community transitions; four staff responsible for supported housing, residential rehabilitation services, Homeless Outreach and crisis respite apartments; one staff responsible for intensive case management and case management, and, one staff responsible for administrative support. The adult mental health staff members provide programmatic and policy expertise and direction to many enterprise initiatives as well as other intergovernmental and interagency collaborations. They have developed memoranda of understanding and other types of partnerships with organizations including the Division of Aging Services within the Department of Human Services, the Department of Community Health, the Department of Community Affairs, the Department of Vocational Rehabilitation Services, and the Department of Public Health, Department of Community Supervision, Department of Corrections, and other governmental and non-governmental agencies.

Georgia statute assigns specific responsibility for developing programs for children and adolescents in need of mental health services to DBHDD. The **Office of Children, Young Adults, and Families (OCYF)** (formerly referred to as the Office of Child and Adolescent Mental Health) within the Division of Behavioral Health is primarily focused on child and adolescent mental health services. There is also a focus on transition age youth and young adults through age 26. In partnership with DBHDD's OAMH and OFGP/CLC, efforts have been put forth to ensure the design and delivery of a behavioral health system that is fully responsive to emerging adults with serious mental health conditions.

OCYF is supported by the Office Director, who is the primary point of contact on all child and adolescent mental health considerations. The office is organized into five practice areas: Clinical Services, Community Based Programs, Parent and Youth Peer Support, System of Care Expansion, and Workforce Development. Clinical Services includes electronic crisis system monitoring, crisis stabilization, mobile crisis response services, and psychiatric residential treatment facilities. Community Based Services includes community innovation grants, high-fidelity wraparound, mental health resiliency support clubhouses, school-based mental health, state-funded system of care grants, and supported education/supported employment. Parent and

Youth Peer Support includes certification training, continued education, and technical assistance. System of Care Expansion involves our latest SAMHSA grant to further expand system of care in Georgia. Workforce Development includes capacity building through ongoing local, regional, and statewide training, including our annual System of Care Academy. DBH's **Office of Addictive Diseases (OAD)** provides leadership for adult and adolescent substance use disorder treatment services. The responsibilities include: program oversight, grants management; ensuring compliance with federal and state funding requirements; maintaining collaborative relationships with advocacy groups and other stakeholders; providing data and information at the regional and local levels to impact policy decisions; statewide technical assistance to providers and the six DBHDD Field Offices; developing and maintaining collaboration among private and public sector providers and stakeholders; providing training and information on best practices for substance use disorder treatment; coordinating collaborative efforts in increasing best practices models; assisting community and faith-based groups in developing capacity and training; overseeing HIV Early Intervention Services among substance users and their families and significant others; overseeing men's residential treatment services throughout Georgia and the Women's Treatment and Recovery Services program; and carrying out gambling prevention activities.

The Office of Addictive Diseases and the Office of Adult Mental Health coordinate treatment and training issues regarding service delivery to those with co-occurring substance use and mental health disorders. By contract and policy, all state providers of services must be co-occurring capable. Georgia has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. In addition, both offices share the same service definitions in the state Provider Manual and work in harmony to ensure that adults, children and adolescents have an integrated system of care.

The **Office of Behavioral Health Prevention (OBHP)** is an office focused on Substance Abuse Prevention, Suicide Prevention and MH Promotion. In February of 2015, OBHP re-organized to reflect some of these common linkages and shared risk and protective factors with Substance Abuse and Suicide Prevention, and Mental Health Promotion. OBHP utilizes a public health approach (population based) and the Strategic Prevention Framework Model (Assessment, Capacity, Planning, Implementation and Evaluation). The OBHP staff currently consist of 19 positions: the Director, an Administrative Assistant, a Strategic Prevention Framework (SPF) System Coordinator and a Data Specialist, a Regional Prevention Specialists Supervisor and four Regional Prevention Specialists, a SYNAR/Special Projects Administrator, a PFS (GenRx) Coordinator, SPF Rx Coordinator, a State Targeted Response (STR) Opioid Coordinator, a STR Opioid Specialist, a Suicide Prevention Coordinator, a GLS Youth Suicide Prevention Director, a Suicide Prevention Specialist, a Leave Specialist, and a SAMHSA Prevention Fellow. Currently there are 14 projects under the Substance Abuse Prevention segment of OBHP and 4 projects under the Suicide Prevention segment of OBHP. The newly added Mental Health Promotion

segment of OBHP is currently under Strategic Planning for incorporation throughout OBHP's work.

The **Office of Deaf Services (ODS)** American Sign Language (ASL) fluent staff include a Director, Clinical Director, Community Services Coordinator (currently vacant), Interpreter Coordinator, and a Staff Interpreter who are committed to providing deaf, hard of hearing, or deaf-blind individuals easy access to behavioral health and developmental disabilities services that lead to a life of recovery and independence. To support the necessary legal mandates of the Belton Consent Order, ODS also employs a Business Operations Analyst and an Administrative Assistant. To assist with the Consent Order compliance processes and project management, DBHDD also provides ODS with a part-time Project Manager. Statewide, ODS has 1 full-time and 17 PRN interpreters trained specifically to provide sign language interpretation in mental health and developmental disability settings. In addition, we have two ASL-fluent Communication Assessors and are currently trying to hire an additional three more ASL-fluent Communication Assessors to provide professional communication assessments of language access needs for the people we serve across the state. Finally, ODS has developed a contract with a DBHDD Community Service Board, Avita Community Partners, to develop and maintain sufficient numbers of ASL-fluent Therapists and Case Managers both in-person and via telemedicine to provide linguistically accessible and culturally competent services to this vulnerable population across Georgia. ODS works closely with the Division of Developmental Disabilities to partner with a community non-profit to provide ASL instruction and training to those providers who are serving individuals who have a hearing loss and communicate in sign language.

The Office of Recovery Transformation (ORT) has its roots in the former Office of Consumer Relations which was formed in 2000. Under the leadership of its Director (a Certified Peer Specialist) and through the work of an Assistant Director, and in collaboration with staff from other Offices, ORT brings the voice of lived experience from adults and youth in recovery from mental and/or substance use disorders, as well as parents of youth with SED and/or other behavioral health conditions, to inform, guide and support DBHDD's transformation to a Recovery Oriented System of Care (ROSC). ORT partners with an internal steering committee of DBHDD leadership as well as the Georgia Recovery Initiative, a group of community advocates, providers, and people in recovery, to exchange information, vet ideas and inform their work. While recognizing the seven building blocks of a ROSC, the ORT is currently focused on aligning behavioral health treatment with a recovery-orientation; increasing understanding about how to partner with Certified Peer Specialists to integrate their unique and valuable contributions into the behavioral health care system; advancing the development of the Certified Peer Specialist workforce; and developing grass roots leadership to mobilize and activate local recovery communities that offer education about and connection to treatment and recovery resources for mental and substance use disorders.

The **Office of Federal Grant Programs and Cultural and Linguistic Competency** (OFGP/CLC) is an office that focuses on management of federally-funded and other grant programs, DBH special initiatives, and as of September 2019 the Office has been tasked with further developing the DBH infrastructure/framework for cultural and linguistic competency and coordinating related training and technical assistance internally and externally for DBH contracted providers. The Community Mental Health Services Block Grant (MHBG)and the Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Grant are managed/co-managed through OFG/CLC. In addition, the Director of this office provides management support and oversight for DBHDD's partnership with the Department of Public Health on the SAMHSA Project LAUNCH grant. Currently, there are two programmatic staff in this office: First Episode Psychosis Project Coordinator, and the Young Child Wellness Partner for Project LAUNCH. The Director also works collaboratively within DBH to ensure successful implementation of any other grant goals and objectives. In addition, she provides staff support to the Behavioral Health Planning and Advisory Council (BHPAC) for the MHBG.

The **Office of Field Operations (OFO)** for behavioral health is an integral part of the Division of Behavioral Health team. The Director of Field Operations (DFO) leads this office and is responsible for overseeing and managing the efforts of six regional field offices, each lead by a Behavioral Health Regional Services Administrator (RSA). The RSA is responsible for overseeing the local systems of community-based behavioral health (BH) services for their respective region with help approximately six direct reports.

The Director of Field Operations directs the day-to-day operations for the OFO for Behavioral Health to ensure continuity related to the Division of Behavioral Health at the regional level. The Director serves as an advisor to DBHDD on a wide variety of complex issues, including statewide and inter-regional issues. The Director ensures service needs identified by the Regional Field Offices and Regional Advisory Councils are submitted to DBHDD in order to inform them on issues that could affect policy, strategic planning, and the budgetary process. Additionally, the position develops and maintains effective working relationships with stakeholders statewide advocating for maximum integration of services and/or functions between community and state hospital systems to ensure seamless continuity of care for consumers and utilization of appropriate referral processes.

The **Office of Crisis Coordination** is an enterprise Office designed to look at the crisis system from a high level and make recommendations to programmatic leaders for system change and improvement. With purview into the Division of Developmental Disabilities, Division of Behavioral Health, and the Division of Hospital Services, the Director of the Office of Crisis Coordination works to ensure the appropriate data and trends are analyzed to equip leaders in

making capacity, quality, and system decisions. The office works with the Divisions to create cross-communication and programming to meet the needs of all individuals served through DBHDD.

This Office is also responsible for the oversight and enhancements to the crisis live referral board. The most recent updates have been funded in part through a TTI grant through NASMHPD. The Georgia Crisis and Access Line (GCAL) manages the platform and provides electronic monitoring of all individuals who need placement in the crisis system as well as a live census of bed availability across the system.

DBHDD Regions

The DBHDD system of services is administered through 6 Field Offices that serve Georgia. These offices administer the hospital and community resources assigned to the region. The regional field offices are first point of contact for any questions about local services. The regional field offices are responsible for: 1) locating and coordinating services and supports; 2) monitoring the services being received by consumers to ensure quality and access; 3) developing new services and expanding existing services as needed; 4) investigating and resolving complaints; 5) conducting special investigations and reviews when warranted; and 6) overseeing statewide initiatives. Regional Offices are the administrative offices of the Department, responsible for the implementation and administration of the plans, policies, and directives issued by the Department.

The Regional Field Offices ensure that services brokered by DBHDD are implemented and provided according to design "Easy access to high-quality care that leads to a life of recovery and independence for the people we serve." These Offices support the network of providers in their regions to assure a full array of services and supports to individuals needing publicly funded services. Each Field Office is managed by a Regional Services Administrator (RSA). These RSA's develop and maintain effective working relationships with all stakeholders in the Region through regular meetings with providers, consumers, family members, advocates, elected officials, and other social services agencies. Under broad supervision of the Director of Field Operations, the Regional Service Administrators are responsible for managing and overseeing a system of community-based Behavioral Health services for the regions. This means working closely with Regional Advisory Councils (RAC), local community collaboratives, providers both in and out of network, DBHDD Central Office, the Director Field Operations, and their counterparts across the state to assure continuity and quality of services across regions Referenced earlier was the partnership/meetings each region has with the Regional Advisory Council (RAC). Specifically, the role the RAC plays with each Field Office is to promote public awareness of mental health, developmental disabilities, and addictive diseases disorders, and to help the public better understand individuals and their needs and services. RAC members stay informed about local needs and issues, and serve as advocates with public officials. The

main objective of the RAC is to assist the department in fulfilling its vision of "easy access to high-quality care that leads to a life of recovery and independence for the people we serve." These advisory councils are required to have at least 50% of their membership comprised of consumers and family members to assure the inclusion of the consumer/family voice in determining needed services for the local region.

Listed below are examples of some specific duties and/or functions of the Field Offices; however, not meant to be all inclusive:

- Responsible for managing and overseeing a system of community-based Behavioral Health services for the region, ensuring accountable and effective continuum of care to support Georgians with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment
- Manages and collaborates with State Office staff and the Georgia Crisis Response System for the Region, closely follows/ensures implementation of all Department regulations, directives, and polies.
- Responsible for supervision of regional office staff members' performance of various duties including assisting hospitals, providers, Beacon, GCAL, the ASO, and consumers in implementation of person-center community transition plan; in addition to, resolving consumer and other constituent complaints.
- Facilitate Regional Community Collaborative and Crisis Meetings
- Provides support and assistance to regional advisory councils (RAC) and assisting in the development of annual plans that identifies and prioritizes the needs in the region
- Actively participate in the strategic planning for the Region and ensure local representation of the plans and related implementation strategies
- Partner with other DBHDD Divisions collaboratively to ensure well versed knowledge around current initiatives projects, new program development and policies; ensure effective communication aforementioned to ensure continuity, shared understanding and consistency in execution

The map below shows the location of DBHDD's six regions. The division of Georgia's 159 counties into the six regions is shown after the map.

Region 1 Field Office serves the following 31 counties in North Georgia: Banks, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Hart, Lumpkin, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, White, and Whitfield.

Region 2 Field Office serves the following 33 counties in East Central Georgia: Baldwin, Barrow, Bibb, Burke, Clarke, Columbia, Elbert, Emanuel, Glascock, Greene, Hancock, Jackson, Jasper, Jefferson, Jenkins, Jones, Lincoln, Madison, McDuffie, Monroe, Morgan, Oconee, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Twiggs, Walton, Warren, Washington, Wilkes, and Wilkinson.

Region 3 Field Office serves the following 6 counties surrounding Metro Atlanta: Clayton, DeKalb, Fulton, Gwinnett, Newton and Rockdale.

Region 4 Field Office serves the following 24 counties in Southwestern Georgia: Baker, Ben Hill, Berrien, Brooks, Calhoun, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Seminole, Terrell, Thomas, Tift, Turner, and Worth.

Region 5 Field Office serves the following 34 counties in Southeastern Georgia: Appling, Atkinson, Bacon, Bleckley, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Dodge, Effingham, Evans, Glynn, Jeff Davis, Johnson, Laurens, Liberty, Long, McIntosh, Montgomery, Pierce, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne, Wheeler and Wilcox.

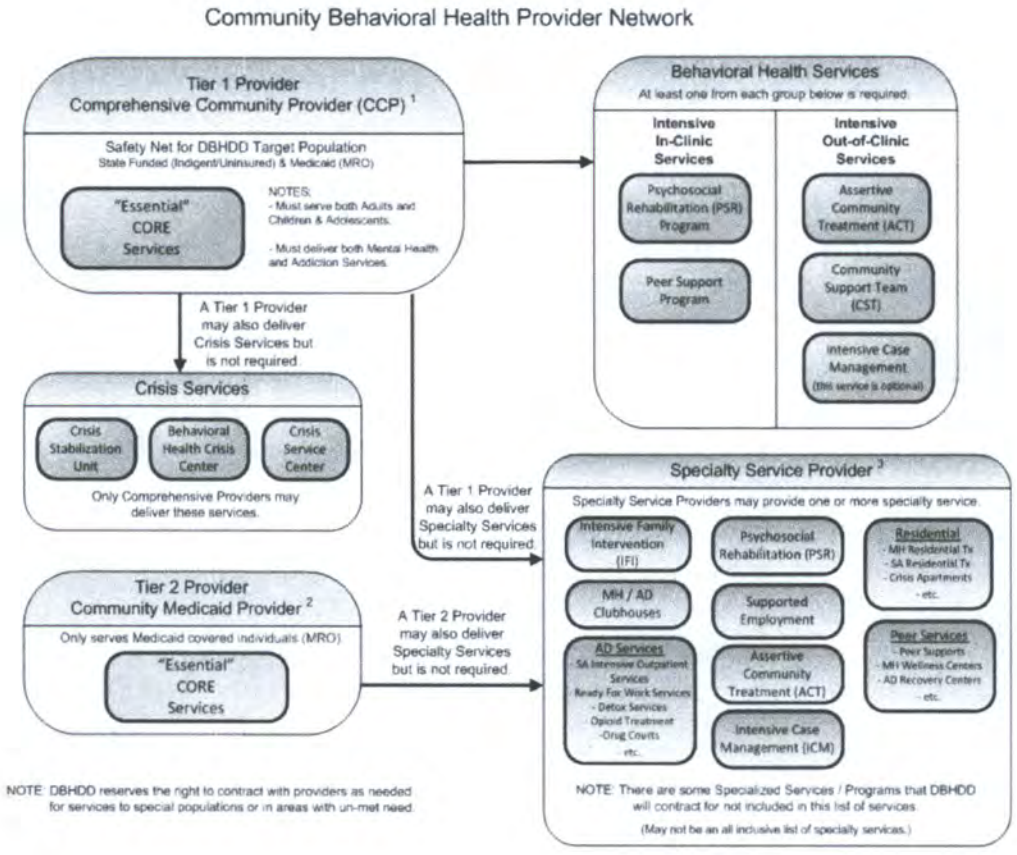
Region 6 Field Office serves the following 31 counties in West Central Georgia: Butts, Carroll, Chattahoochee, Clay, Coweta, Crawford, Crisp, Dooly, Fayette, Harris, Heard, Henry, Houston, Lamar, Macon, Marion, Meriwether, Muscogee, Peach, Pike, Quitman, Randolph, Schley, Spalding, Stewart, Sumter, Talbot, Taylor, Troup, Upson and Webster.

DBHDD Community Providers

DBHDD is responsible for the delivery of services for adults and youth with mental illness, substance use disorders, co-occurring disorders, children with serious emotional disturbances, as well as for people with intellectual and developmental disabilities. The service delivery system and the process for developing and contracting with providers are comprehensive in scope and focused on the value of consumer choice. Community-based services are delivered by a network of private and public providers with whom DBHDD contracts or has letters of agreement. Currently there are over 250 behavioral health providers for DBHDD with 24 of them being Community Service Boards, the public safety net providers.

To establish an effective and accountable continuum of care that is sustainable in a dynamic health care environment, DBHDD implemented three major initiatives directly impacting the provider network, with the intent and expectation that these initiatives would result in higher quality services, statewide consistency, and improved accountability for both providers and the Department's management of community operations. These initiatives included 1) Core Re-design, 2) Georgia Collaborative Administrative Services Organization (ASO), and 3) restructuring of the agency at the state and regional level (described above).

The **Core Redesign** was implemented to improve access, quality, efficiencies, and fiscal accountability within the community behavioral health provider network. Providers in the Department's Community Behavioral Health Provider Network are categorized as shown in the chart below and the tier descriptions that follow the chart.



Tier 1: Comprehensive Community Providers (CCP) - CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The designation of safety net providers (CCPs) is an important step for the system in creating a standardized public benefit across all counties which is accountable and transparent to recipients of services, their families and supporters, and payers. More specifically, CCPs, which are Community Service Boards (CSBs), are DBHDD public providers who operate within a recovery-oriented system of care that has the capacity to deliver comprehensive and vital community mental health and substance use disorder services to identified Georgians. Tier I CCP providers have the unique capacity and infrastructure, including comprehensive staffing and electronic information systems capability, to provide a seamless continuum of behavioral healthcare, without need for multiple referrals and coordination. These providers serve as the clinical home for individuals enrolled in services and receive DBHDD state funds to support infrastructure needed to be a safety net provider. Safety-net providers also typically see a mixture of individuals who are uninsured, as well as insured, on Medicaid, or privately insured.

Each CCP must have the capacity to provide a core benefits package for individuals for whom the service is deemed clinically appropriate. Mental Health/Substance Use Disorder services

include behavioral health assessment/service plan development, psychological testing, diagnostic assessment, crisis intervention, psychiatric treatment, nursing assessment and health services, medication administration, pharmacy and lab services, community support /case management/PSR-1, and individual/group/family outpatient services, addictive disease support services, and peer support. A CCP must also provide at least one intensive in-clinic service such as psychosocial rehabilitation or peer support program and one intensive out of clinic service such as assertive community treatment, community support team or intensive case management. A CCP may also offer other crisis and specialty services such as intensive case management, psychosocial rehabilitation, supported employment, assertive community treatment, residential services, peer services, resiliency support clubhouses, intensive family intervention, community based inpatient psychiatric and substance detoxification services, crisis stabilization unit, behavioral health crisis center, crisis service center, and addictive disease services.

Tier 1 providers operate under 12 CCP Standards. These standards include access to services; crisis management; transitioning of individuals in crisis from inpatient and crisis stabilization care; engagement in care; substance use treatment and supports; recovery oriented care; administrative and fiscal structure; required staffing; accreditation, certification and licensing; benefits eligibility; suicide prevention; and access to housing.

Tier 2: Community Medicaid Providers (CMP) - CMPs provide behavioral health services and supports identified in the Medicaid State Plan for adults, youth, and young adults with a mental health condition or Substance Use Disorder (SUD). A CMP may be age-focused (i.e. only children and adolescents or only adults, or both). A CMP offers the essential core benefit package of services and is **required** to operate in compliance with the CMP Standards as well as all contract or Letter of Agreement (LOA) and Provider Manual requirements. A CMP may also offer specialty services but is not required. CMPs also follow standards that closely resemble Tier 1 standards.

Tier 3: Specialty Providers (SP) – Specialty Providers may provide one or more specialty services: Assertive Community Treatment, Intensive Family Intervention, MH & AD Clubhouses, Peer Services, Psychosocial Rehabilitation, Supported Employment, Intensive Case Management, Addictive Disease Specialty Treatment, Residential Services and Peer Services.

As mentioned above, Community Service Boards are the established public providers of mental health, developmental disability and addictive disease services, the designated safety net providers and are therefore classified as Tier 1 CCPs. The provider network also includes private provider agencies offering core services as well as a variety of specialized services as Tier 2 and Tier 3 providers.

Through a standardized provider application process, organizations are encouraged to apply to become authorized providers to increase consumer choice. All Behavioral Health providers under contract with DBHDD must adhere to the Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Behavioral Health, which includes core requirements and utilization guidelines for all providers. The requirements identified in the manual assure that an organized and standard system of care is available to citizens of Georgia wherever they live in the state and according to individual need. Services are required to be provided in a culturally appropriate and competent manner by providers with a workforce trained to recognize and address diverse needs. All Providers must be accredited at the time of application and continuously recredentialed by one of the following organizations: The Joint Commission (TJC), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Council on Quality and Leadership (CQL).

DBHDD Administrative Services Organization

The Georgia Collaborative ASO (ASO) is the administrative services organization (ASO) for DBHDD. The ASO provides administrative services in support of Georgia's public, integrated behavioral health and intellectual/developmental disability service system. The ASO provides these supports for adults and children who are eligible for fee-for-service Medicaid and those who are uninsured, as well as and individuals with IDD. Operating as the Georgia Collaborative ASO, three companies partner together as a Collaborative vendor including Beacon Health Options, Behavioral Health Link (BHL), who provides telephonic crisis intervention, and preferred single-point-of entry services and mobile crisis dispatch as the Georgia Crisis and Access Line (GCAL), and Q'larant (formerly the Delmarva Foundation), who provide quality reviews and trainings for DBHDD contracted providers who serve individuals with IDD. The goal of the partnership is to improve coordination, increase efficiency and support high-quality care for individuals served by the department.

Some highlights of the Collaboratives' functions include:

- Maintaining the 24/7 Georgia Crisis and Access Line for behavioral health and developmental disability services
- Deploying integrated information technology system for behavioral health and developmental disabilities
- Using state-of-the-art technologies to create efficiencies and improve the quality of care
- Quality management and consultation for all behavioral health and developmental disability providers
- Providing focused utilization management and review services

MENTAL HEALTH SERVICES SYSTEM DESCRIPTION

Following are descriptions of the Adult Mental Health and Child and Adolescent Mental Health systems organized by Criterion required for the Mental Health Block Grant application. Three criteria are included for the adult description in this section: Criterion I: Comprehensive Community-based Mental Health Service System; Criterion IV: Targeted Services to Rural, Homeless, Older Adult and special populations; and Criterion V: Management Systems of Human and Fiscal Resources. Four Criteria are included for the child and adolescent description: Criterion I: Comprehensive Community-based Mental Health Service System; Criterion III: System of Integrated Services, Criterion IV: Targeted Services to Rural and Homeless; and, Criterion V: Management Systems of Human and Fiscal Resources. One additional criterion, Criterion II: Mental Health System Data Epidemiology is discussed in a separate section on Unmet Needs for adults, children and adolescents.

ADULT MENTAL HEALTH

Criterion I: Comprehensive Community-based Mental Health Service Systems

Georgia provides a comprehensive community-based system of mental health care for adults with serious mental illness who need public services. An array of community based mental health services is provided in each service area of the state, including evidence-based practice services identified as most effective for individuals with serious mental illness. While not all services are available in every one of Georgia's 159 counties, each county is included in one of the state's 25 service areas. The array of services is provided in the lead counties of the services areas, at a minimum, with some services available in satellite offices or through mobile service delivery. Additionally, the state continues to enroll core providers throughout the state to allow for consumer choice among service providers. Consumer choice is a transformation project that has empowered consumers and shifted providers' expectations about how they need to provide services in order to attract consumers.

Georgia continues to advance evidence-based practices and promising practices. DBHDD has focused considerable attention on developing and implementing evidence-based practices within the mental health service system through dissemination of information and through pilot demonstration projects. As a result of this emphasis on best practice, the mental health system in Georgia has implemented Evidence-Based Practices (EBPs) in various parts of the state. The EBPs used within the state include Assertive Community Treatment (ACT), Individual Placement and Support (IPS) Supported Employment, Motivational Interviewing (MI), Housing First Permanent Supported Housing, and Integrated Dual Diagnosis Treatment (IDDT). In addition, Georgia has been a leader in the development of Peer Support Services and has implemented a Forensic Peer Mentor initiative. DBHDD also contract for the delivery of an

array of crisis services. All of these services provide a system of care for adults, support recovery of individuals and provide opportunities for a meaningful life in the community.

With an increased emphasis on growing our community system, and insuring that individuals can access the services and supports needed to experience the highest quality of life possible in the community, the DBHDD has expanded the delivery of services across the state, to include increased numbers of persons served in Supported Employment, expanded the array of crisis services including increased crisis respite apartments and behavioral health crisis centers, and expansion of behavioral health accountability courts.

Of significance to Georgia, the Department of Justice filed a separate lawsuit against the State, DBHDD and the Department of Community Health (DCH) alleging violations of the American with Disabilities Act (ADA). DOJ alleged that Georgia failed to "administer services in the most integrated setting appropriate to the needs of qualified individuals with disabilities". The Governor and the two Commissioners signed a Settlement Agreement which was entered by the court on October 29, 2010. The settlement agreement addresses consumer rights related to safety and effectiveness of state operated psychiatric hospitals. It primarily addresses the provision of increased community-based services under the ADA and in accordance with the US Supreme Court's Olmstead decision. Under the settlement agreement, a target population is defined; 9,000 persons with severe and persistent mental illness who are currently being served in state operated hospitals; frequently readmitted to state operated hospitals; frequently seen in emergency rooms due to mental illness; chronically homeless; and/or released from jails or prisons. Georgia is required to provide expanded and enhanced community services for target population individuals via any of the following services include Assertive Community Treatment (ACT), Community Support Team (CST), Intensive Case Management/Case Management, Supported Employment, Crisis Respite Apartments, Supported Housing, and an array of crisis services. Georgia implemented and is sustaining all of the required behavioral health treatment services, and achieved compliance with those behavioral health treatment services targets in the fall of 2016. One remaining behavioral health non-treatment program- Supported Housing, remains in the Settlement Agreement Extension, which was signed in the fall of 2016 and scheduled to end 6/30/18. The following targets were achieved:

#	New Adult Mental Health Community-Based Services Description
22	Assertive Community Treatment Teams
10	Community Support Teams
14	Intensive Case Management Teams
52	Case Management Services
3	Crisis Stabilization Programs
10	Behavioral Health Crisis Centers

4,054	Persons receiving state funded Supported Housing
4,342	Persons receiving Bridge Funding
1,200	Persons receiving Supported Employment Services
835	persons receiving Peer Support Services
18	Crisis Respite Apartments
159	Counties with Mobile Crisis Service coverage

An independent Reviewer and multiple subject matter experts chosen jointly by the state and DOJ routinely evaluate the state's compliance with the terms of the settlement agreement and produce reports to the Court twice a year.

Assertive Community Treatment

DBHDD currently contracts with providers for statewide delivery of ACT services in all 6 regions in the state of Georgia with funding and support for 22 state contracted and four Medicaid Rehabilitation Option (MRO) teams. In addition to financial support, the ACT teams also receive from the state office technical assistance and guidance from the DBHDD three-member ACT and CST Services Unit. Annually, this team completes a fidelity review for each of the 22 contracted and four MRO teams utilizing the Dartmouth Assertive Community Treatment Scale to ensure that all ACT teams in the state of Georgia are operating with fidelity to this model. Throughout the year, ACT teams receive consultation from the ACT and CST Services Unit as well as several training initiatives which were provided by DBHDD through national experts and consultants. Training topics included the following: transition planning, Integrated Dual Disorder Treatment, Collaborative Documentation, Recovery-oriented Cognitive Behavioral Therapy, Recovery Oriented System of Care, Dialectical Behavior Therapy, Motivational Interviewing, Disaster Preparedness, Self-Care, Effective Team Leadership, Trauma Informed Community Based Service Delivery, and Housing First Model Training. At the conclusion of the annual fidelity reviews for all ACT teams DBHDD initiated a fidelity roundtable discussion, allowing a forum for provision of feedback and input from all providers about the review process and overall ACT operations. ACT Coalition meetings are conducted bimonthly and are held in a central location of the state. All ACT providers throughout the state are able to attend the meeting in person, access the meeting via conference telephone line and/or use a video access line where they can view the meeting live online. ACT Coalition meetings provide a forum for distribution of relevant information and receipt of feedback from providers. During coalition meetings there are also presentations on various topics that are useful in the delivery of the ACT services. Presentations in the past have included but are not limited to strategies for ACT teams to assist individuals in obtaining benefits and/or employment, housing resources and options for homeless individuals, ACT team collaboration with local jails, engagement strategies, and delivery of Substance Abuse treatment within the ACT model. Additionally, the ACT and CST Unit facilitates role-specific support calls for members of the

team to share best practices within their scope of work with others in the same role across the state. These calls typically take place monthly.

Employment Services

Supported Employment Services

A portion of Georgia's MHBG allocation funds the capacity to provide Supported Employment (SE) services to over 2200 adults with mental illness each month. In addition to MHBG funding we allocate state funds for Supported Employment for individuals that are identified under the ADA Settlement Agreement as meeting criteria for serious and persistent mental illness (SPMI) which supports SE service for 570 individuals; DBHDD's contracted SE providers are now funded to serve 2,790 individuals each month. Also, in FY17 the Office of Children, Young Adults and Families provided funding inclusive of 105 slots to serve Transition Aged Young Adults ages 18-25.

The increase in SE services also provides the department the opportunity to continue to implement provider training on evidence-based practice SE (EBP SE) also known as the Individual Placement & Support (IPS) Model. In FY19 and continuing into FY20, DBHDD provided training via SE Provider Coalition meetings; and by funding scholarships to the Statewide GA-APSE conference, SE Supervisor Retreat, and 5 IPS Webinar Series for SE supervisors and Employment Specialists. Technical assistance was also provided during onsite IPS fidelity reviews of DBHDD's contracted providers.

In FY19 and continuing into FY20, DBHDD will continue to require SE Providers to submit a monthly SE programmatic report, which is used to calculate payment as well as track compliance with contract deliverables, quality performance measures, and fidelity to the IPS model. Collected data was used to support determination of funding allocations as well as training and technical assistance needs.

DBHDD continues our partnership with the Georgia Vocational Rehabilitation Agency (GVRA), Vocational Rehabilitation program (VR). Both agencies continue to work in a more coordinated and efficient manner, in accordance with federal and state regulations to provide EBP SE services and support more individuals with SPMI in meeting their vocational and employment goals. In FY19, the Georgia IPS Initiative has currently to date provided services to 3100 dually enrolled persons benefitting from DBHDD Adult Mental Health IPS Supported Employment and VR Employment services. We currently have 1133 actively dually enrolled.

CMS has approved DBHDD's use of Task Oriented Rehabilitation Services (TORS), originally proposed as Employment Rehabilitation Services. This service has been fully implemented and available to all DBHDD state contracted SE Providers. DBHDD state office staff continues to ensure that this service correlates with the SE service definition to reflect IPS fidelity standards.

Supported Housing

DBHDD seeks to empower people to overcome barriers to obtaining permanent housing, which includes access to the right kinds of supports and care to get and keep their housing, and improve their quality of life—some individuals benefit from intensive services and structured programs, while some individuals benefit from housing support programs aimed at assisting them to afford housing without the intensive, program-based treatments supports that others need to remain housed. All of these programs make up a continuum of housing programs aimed at empowering individuals to achieve and remain stably housed as in recovery.

The continuum of residential services model allows DBHDD to focus on matching the right level of housing supports and services to people's needs and strengths. There are some who might just need long-term rental assistance or affordable housing coupled with case management supports; others may need more intensive residential supports that allow them to remain in the community. A responsive and capable supported housing continuum provides housing and services supports at these ends of the spectrum, as well as those levels of housing programs of support and services in between.

The idea that some of the programs within the DBHDD Supported Housing Continuum sometimes require "intensive" services should not be taken to mean that the focus of services is only on therapeutic or treatment goals. In fact, the DBHDD Supported Housing Continuum emphasizes services and supports that focus on housing stability and using housing stability as a platform for connecting people to the types of services and care that they seek for gains in health, recovery, and well-being. Housing is considered to be so key to a person's health, recovery, and well-being that some "intensive" types of housing-based, residential services are needed within a continuum of care to increase the stability and focus on housing as the platform for stability and advancement in other areas of life. In this way, DBHDD's Supported Housing Continuum is based on the premise that people need to have available to choose from different levels of housing supports and programs that will allow them success in health, well-being, and recovery to achieve stability in their housing, which then is the basis for other gains in their recovery.

The DBHDD Supported Housing Continuum is—first and foremost—about health and well-being. The DBHDD Supported Housing Continuum is built upon and emphasizes choice among different levels of housing support intensity to meet their recovery goals. DBHDD recognizes that health and recovery are so much more attainable when people have a safe and stable home with options for individuals to have the level of services supports and intensity that affords them the freedom of how they progress in their recovery.

DBHDD began using results-oriented program evaluation for the supported housing program in 2019.
DBHDD considered several program evaluation theories and approaches, and DBHDD specifically chose a program evaluation theory- and evidence-based approach that is purposefully used by management to achieve measurable indicators of performance and progress towards program outcome objectives related to program goals (Shadish, et al., 1991). Wholey's program evaluation theory and approach emphasizes the following, which are key to improving and developing the DBHDD supported housing program:

- •Utilization of program evaluation approaches that emphasize action and change based on accumulation of knowledge;
- •Target audience of the evaluation is managers that are focused on program performance and improvement;
- •Pragmatic approach to solving problems through incremental and accumulated improvements;
- •Produces valid, objective knowledge to develop and manage programs to achieve desired outcomes;
- •Program evaluation information and processes that assist in moving the program to be prepared to be managed for results;
- •Focuses management attention on providing specific goals that bear on actual activities, to which management is willing to indicate accountability; and
- •Program evaluation information is part and parcel not only to program operations but also program improvements.

In order to be successful, DBHDD has established timelines and processes for reviewing and comparing against baseline and performance targets for process and outcome indicators. Every six months, upper management reviews process monitoring information and data to ensure the program is upholding the principles of supported housing by providing the critical elements of the model.

As of August 2019, DBHDD has adapted SAMHSA fidelity scale and general organizational index has critical tools for this component of the performance monitoring system, and these tools are consistent with basic guidelines for program evaluation.
•Additional information about the program and the people who participate in the program is also reviewed to provide a fuller picture of how the program works to meet the goals of supported housing and individuals in supported housing.

As indicated by SAMHSA, the scales and tools (that DBHDD adapted) were designed and based on an ideal supported housing program, and it is not expected that supported housing programs score the perfect score of 28. However, a score of at least 21 or 75% is necessary to achieve

fidelity. This information will be taken into consideration as DBHDD evaluates and establishes performance targets based on the adapted, modified performance monitoring scale.

In FY08, the Department of Community Affairs (DCA) and DBHDD entered into a partnership to expand access to housing resources for homeless individuals with behavioral health disabilities. The two Departments have been working cooperatively to establish supported housing programs and assist eligible individuals in obtaining and maintaining safe, affordable, independent housing. DCA provides many financing programs to develop housing and DBHDD provides the services and supports needed to assist people in remaining in their communities of choice. DBHDD continues to strengthen partnerships that can increase the availability of permanent supported housing for those with serious mental illness who are homeless.

Georgia settled with the Department of Justice under the Americans with Disabilities Act. As part of the agreement, DBHDD operates a housing voucher program targeting persons with serious and persistent mental illness transitioning out of institutional settings and those who are chronically homeless.

The 2018 Annual Homeless Assessment Report (AHAR) to Congress identified Georgia as one of the highest rates of unsheltered chronically homeless at 76% (992 – homeless and 754 unsheltered). According to the AHAR, 9 in every 10,000 people experience homeless with a total of 9,499 total homeless in Georgia with 6,943 individuals and 2,556 people in families with children. Supported housing is recognized as a national evidence based best practice by SAMHSA aimed at providing cost savings to states by supporting chronic populations that are high utilizers of services who often cycle frequently through various public institutions at great cost to taxpayers. Within the State of Georgia, access to the DBHDD Georgia Housing Voucher and Bridge funds allows the most chronic population of adults with severe and persistent mental illness to access the supports and services that promote housing stability. Thereby reducing the frequency with which this population of individuals uses other state resources. Stable housing has been linked to reduction of legal involvement/crime and hospitalization. Access to the GHV and Bridge funds allows one of the most vulnerable disabled populations in our state – those with severe and persistent mental illness (SPMI)-- affordable housing with the supportive services necessary to reduce individual's admission to state psychiatric hospitals, emergency rooms, and jails/prisons.

In FY 2017, DBHDD and DCA expanded their MOU and created a shared position to cooperatively advance the collective housing efforts of both agencies. The Supported Housing Program will move forth the goals of supporting providers of both housing and residential services as well as meeting and sustaining the supported housing requirements of the Settlement Agreement Extension. This includes, increasing access to supported housing for our target population, maximizing state resources for supported housing for our target population,

operationalizing a statewide unified referral process for supported housing, and continuing the work of oversight of the statewide supported housing need and choice survey. This unit will work in collaboration with the DBHDD and DCA regional field offices, community BH providers, hospitals, state and local agencies and law enforcement to support comprehensive implementation of strategies that will promote supported housing access statewide.

In response to the Settlement Agreement the Department implemented the Need for Supporting Housing Survey (NSH) to assess the need for supported housing for individuals meeting DOJ settlement criteria. As of August 2019, the Need for Supported Housing (NSH) reports that 61% of individuals (1328) were in need of supported housing.

The FY 2018 Georgia PATH Annual Report indicates that 4,500 people were contacted by the PATH program. Of those contacted, 2,545 were actively enrolled in PATH with 52% chronically homeless and 57.8% with a primary mental health diagnosis with no substance use co-occurring disorder.

DBHDD is currently partnering with state and local re-reentry initiatives to ensure that those with serious mental health needs being released from jails/prisons have access to community-based services and supported housing.

Supported Housing Accomplishments include:

- Since inception of the US DOJ vs GA Settlement Agreement, 4,757 individuals served by the Georgia Housing Voucher.
- Across the state, the Department contracts for PATH services (Projects for Assistance in Transition from Homelessness), these are teams of case managers whose sole focus is to work in communities across the state connecting homeless persons who have behavioral health needs with housing and services.
- Each year of the Settlement agreement, the Department has exceeded the #s of persons required to be served via the GHV and Bridge programs because we know that stable housing is integral to achieving a life of independence and recovery.
- DBHDD is now one of the largest subsidized rental subsidy programs in the state.
- As important as it is to assist individuals in obtaining safe and stable housing, it is equally vital to offer the supports and access to services that will help someone maintain their housing. This is the beauty of our system; DBHDD has a network of dedicated, hardworking behavioral health community service providers who deliver Community Support Team (CST) and Assertive Community Treatment (ACT) and Intensive Case Management (ICM) for persons with serious mental illness, supporting people with skills building and recovery planning in a way that helps people remain stable and housed in their community.

- The GHV program has a housing stability rate of 94%, meaning, a very high number of individuals who are living in supported housing apartments funded by the GHV remain stably housed for 6-months or more.

Peer Support Services

A portion of Georgia's MHBG allocation funds the capacity to provide peer supports. Georgia's Peer Support Services are led by Certified Peer Specialists who promote recovery, wellness, socialization, self-advocacy, development of natural supports and life goals, and maintenance of community living skills. Activities facilitated between peers must promote self-directed recovery by exploring consumer purpose beyond the identified mental illness and possibilities of recovery; tapping into consumer strengths related to illness self-management; emphasizing hope and wellness; and by helping consumers work toward achievement of specific personal recovery goals, which may include meaningful employment; and by assisting consumers with relapse prevention planning. CPSs have been trained in the essential skills of peer mentoring/coaching including active listening, motivational enhancement, and how to use their personal recovery experience to encourage and support others.

Georgia offers an array of Peer Support Services. Peer Support Programs provide structured group activities that are provided between and among individuals who have common issues and needs; are consumer motivated, initiated and/or managed; and assist individuals in living as independently as possible. A Peer Support Program may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which individuals can meet and provide mutual support.

Agencies that operate Peer Support Programs and Tier I and Tier II providers may also provide Peer Support Services – Individual, in a 1:1 modality between a CPS and a person served. Individuals participating in the service must have the opportunity, at any given time, to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist/s. Individuals should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.). This service may be provided in the clinic or community.

Peer Support Whole Health & Wellness is provided in a 1:1 modality between the person served and a CPS with additional certification as a Whole Health & Wellness Coach. Whole Health and Wellness Coaches have additional training in whole health wellness, relaxation response techniques, mind-body interventions, nutrition, stress management and smoking cessation. A designated nurse provides consultative support to Whole Health and Wellness Coaches who assist individuals with setting personal expectations, introducing health objectives as an approach

to accomplishing overall life goals, helping identify personal and meaningful motivation, and health/wellness self-management. The individual served is supported to be the director of his/her health by identifying incremental and measurable steps/objectives that make sense to the person. Health engagement and health management for the individual are key objectives of the service. These should be accomplished by facilitating health dialogues; exploring the multiple choices for health engagement; supporting the individual in overcoming fears and anxiety related to engaging with health care providers and procedures; promoting engagement with health practitioners including, at a minimum, participating in an annual physical; assisting the individual in the work of finding a compatible primary physician who is trusted; among other engagement activities. Another major objective is promoting access to health supports. This is accomplished by using technology to support the individual's goals; providing materials which assist in structuring the individual's path to prevention, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his/her own natural support network which will promote that individual's wellness goals; creating solutions with the person to overcome barriers which prevent healthcare engagement (e.g. transportation, food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the individual with other health and wellness resources (physical activity, fitness, healthy/nutritional food).

The above 3 types of Peer Support services are Medicaid-billable and provided across the state by behavioral health service providers. Georgia also offers specialized Peer Support Services via a contract with the Georgia Mental Health Consumer Network, a consumer-operated agency that is Georgia's largest employer of individuals in recovery from mental illness. These services include 5 Peer Wellness and Respite Centers and a Peer Support Warm Line.

Double Trouble in Recovery (DTR) is a 12-step self-help recovery support group for individuals with co-occurring mental health and substance use disorders. GMHCN trains DTR group leaders and coordinates sixty weekly DTR meetings across the state. Meeting locations include State Hospitals, Mental Health and Drug Courts, Department of Corrections Day Reporting Centers, Behavioral Health Treatment Centers, Residential Programs, medical centers, churches, and public libraries.

The GMHCN Peer Mentor Program offers one-on-one peer support services provided by CPSs to facilitate individuals' transition from long-term hospitalization to community living; or support individuals who frequently utilize Crisis Stabilization services to increase connection to community services and supports. Two half-time Peer Mentors are assigned to each of the six DBHDD regions to engage with interested individuals and assist them in making informed choices in their transition planning process. This may include taking an individual into the community to meet potential community service providers or explore housing options. Peer Mentors follow individuals into the community for up to two years, to support adjustment to

their new home and service providers; help them explore interests and make linkages with natural supports in the community such as churches, civic groups, etc.; and establish a meaningful daily life. The Peer Mentors advocate for the individuals and teach them to advocate for themselves.

In SFY14 DBHDD increased state funding in GMHCN's contract to open two more Peer Support, Wellness and Respite Centers (PSWRCs), increasing the statewide total to five. The PSWRCs provide an alternative to psychiatric hospitalization by offering free respite services up to a week at a time to individuals who have established relationships with the all-peer staff. The PSWRCs also provide daily walk-in peer support and wellness activities and operate a 24/7 peer support warm line, which can facilitate warm transfers to the Georgia Crisis and Access Line if appropriate.

Forensic Peer Mentor Pilot Project Outcomes
(A' r '15 – May '16)

Facilities staffed = 11

Enrolled = 216

Transition planning sessions = 5,367

Program outcomes
(DRC & Hospital Participants + Post-release from Prison Returning Citizens)

Stable Housing	Avg. 90%
Employed	Avg. 67%
Linked to MH Services	Avg. 73%
Psychiatric hospitalizations	0%
New Arrests	10% *

*Only participant with a new conviction had outstanding warrant that was not resolved during prior prison stay; was convicted on that charge following release.

In SFY15 DBHDD contracted with the GMHCN to develop a pilot Forensic Peer Mentor Program in partnership with the Georgia Department of Corrections (GDC) and the Georgia Department of Community Supervision (DCS). CPSs and/or Certified Addiction Recovery Empowerment Specialists (CARES, aka CPS-AD) were provided 40 hours of additional training to support individuals with behavioral health conditions to successfully transition from incarceration in prison to community living. Individuals identified by behavioral health clinical staff at program sites, who elect to participate, are paired with a Forensic Peer Mentor who offers assistance with self-direction in choice of services and supports; behavioral health care, housing, employment, service providers, etc., in transition planning, and in executing the plan to ensure connection with community services, employment and development of natural supports. In FY19 15 Forensic Peer Mentors provided 12,000 transition planning and support sessions to 479 Returning Citizens in state prisons, Day Reporting Centers (probation/parole), state psychiatric hospital forensic units, and Mental Health Treatment Courts. This table shows program outcomes for the pilot year of the program (April 2015 to May 2016).

Georgia Crisis and Access Line

Via contract with DBHDD, Behavioral Health Link (BHL) operates the Georgia's Crisis and Access Line (GCAL). GCAL's professional, clinical staff provide 24/7 telephonic crisis intervention and linkage to DBHDD services state-wide through a toll-free, confidential hotline available 24 hours a day, 7 days a week from anywhere in Georgia. It connects callers with a trained, professional who can help them get the services they need if they or someone they know or are caring for are in emotional distress, behavioral health crisis, a suicidal crisis, or even a crisis related to an intellectual/developmental disability.

The hotline is staffed by trained and caring professionals who are available around the clock to provide help and hope. The primary goal is to help connect individuals with care quickly, close to home, and to avoid unnecessary law enforcement or emergency department intervention. GCAL receives nearly 1,000 contacts on most business days and makes nearly as many outbound contacts to coordinate care. Nearly 40% are individuals calling for themselves. 16% are calling for their friends or family. A surprising 46% are professionals seeking support for an individual under their care or in their services. Professionals call GCAL from emergency rooms, community mental health centers, private psychiatric hospitals, family and children services, courts, schools, law enforcement, probation and parole, juvenile justice, and many others.

GCAL is the single point of mobile crisis dispatch statewide and serves as the preferred point of entry for Crisis Stabilization Units. As a CARF accredited Crisis and Information Call Center, a URAC accredited Health Call Center and as the only AAS certified crisis center in the State of Georgia, BHL's call center in Atlanta answers over 250,000 calls annually and in 2016 handled over 160,000 distinct episodes of care.

DBHDD and GCAL partnered in 2019 to establish a GCAL text line initiative. Georgia's youth can now access GCAL's services via text and chat through a new app called My GCAL, which became available for download in late January 2019. The app will allow individuals to call, text, or chat with GCAL 24/7/365, choosing how they want to reach out for help.

Recovery Support Services

Recognizing that recovery emerges from hope, and is supported by peers and allies, DBHDD funds a variety of peer support services in group and individual formats, within the formal system of BH care and outside of it, in the community. Within DBHDD's formal system of care, Certified Peer Specialists (CPSs) provide group and one-on-one peer support services, as well as Whole Health & Wellness Peer Support which supports individuals in working toward behavioral and whole health goals. DBHDD requires employment of CPSs on Assertive Community Treatment Teams as well as Mobile Crisis Teams, and encourages utilization of CPSs in the provision of other services for which they're qualified. Through the Recovery-Focused Change Training & Technical Assistance (RFT) initiative with Tier One providers, CPSs have been instrumental in helping provider agencies create a more hopeful and welcoming

climate in waiting rooms of service facilities. In some instances, CPSs are employed as Engagement Specialists, to help orient individuals to the treatment system and understand their rights and responsibilities for participation in treatment services.

When individuals with SMI are hospitalized, they are offered peer support services from a Peer Mentor, who can assist them to actively engage in discharge planning and in making the transition to their new community home. Peer Mentors can help individuals set up household and make solid connections with service providers, and any other groups in the community with whom the individual would like to engage/participate. DBHDD supports individuals in finding housing, and offers housing vouchers to individuals who meet Dept. of Justice Settlement Agreement. DBHDD also offers Supported Employment services for individuals seeking help with employment.

Outside of the formal system, DBHDD funds opportunities for people served to engage in peer support and learn about self-direction, recovery supports, and self-help tools, via the Georgia Peer Support Institute, Annual Consumer Conference, Wellness Recovery Action Plan (WRAP) training and groups, and the Georgia Respect Institute. Five consumer-operated Peer Support, Wellness and Respite Centers offer drop-in wellness activities 7 days a week, respite services for up to 7 consecutive nights, and 24/7 telephonic peer support. Double Trouble in Recovery peer support groups are offered in a variety of community venues for individuals with co-occurring mental and substance use disorders.

DBHDD's long term commitment to developing the peer workforce is paying off in our service system as well as in grass-roots recovery leadership. DBHDD is partnering with the Georgia Council on Substance Abuse and Georgia Mental Health Consumer Network to facilitate, support and nurture the development of local recovery leadership. While the local collaboratives include a variety of community stakeholders including law enforcement, human services, educators, public and private BH providers, faith communities and local businesses, Certified Peer Specialists frequently play key roles in facilitating recovery community dialogues, planning recovery events and creating opportunities for people in recovery to fully participate in their communities.

Transition Services

The Hospital Recovery Planning Teams, Regional Field Office staff and Office of Adult Mental Health Transition Services are responsible for effective transition planning. This planning requires the development of partnerships between individual's hospital staff, field office staff and community care providers. All aspects of person-centered recovery planning rely on shared decision making and individually defined outcomes. Hospital Transition Specialists and Community Case Expediters in the Regional Field Offices are key players who rely on relationships they have established through collaborative efforts to help facilitate individuals

obtaining needed services, and in crisis situations, can often divert individuals from the hospital to appropriate resources in the community. Hospital Transition Specialists and Community Case Expediters are perceived as the link between the hospitals and the community. Each region has Hospital Transition Specialist assigned to work with the state hospital(s) to ensure timely transitions to the community for adult mental health individuals. Hospital Transition Specialists focus on individuals who have been in the hospital over forty-five days and other individuals who face challenges that are barriers to discharge. Community Case Expediters coordinate services for individuals who need assistance navigating the community system of care. Community Case Expediters additionally work with Regional Children, Young Adults and Families (CYF) Program Specialists to ensure coordination of services for young adults leaving hospitals or residential services, who may still qualify to receive Department of Behavioral Health and Developmental Disabilities (DBHDD) supports, Department of Human Services' supports and Public School education.

We recognize the importance of good transition planning to ensure continuity of care for individuals leaving an institutional setting, and we recognize the value of ensuring the individual takes the primary lead for their own recovery and transition activities. Individuals with hospital lengths of stay greater than forty-five days are the focus of intensified transition efforts. Our hospitals are currently using the Individualized Recovery Plan for treatment and transition/discharge planning. Individuals are given the opportunity to participate in planning for their transition with members of their recovery team, the Regional Hospital Transition Specialist, their chosen community care provider, as well as their family members and other stake holders identified by the individual who may play an important role in their life. The planning meeting provides the opportunity to look at the individual's strengths, hopes and desires and what is important to them. This setting provides the venue for identifying barriers, and developing next steps for transition. The team continues to review the transition progress and work through barriers on bi-monthly ADA calls. This process keeps us focused and assures that we recognize and work through barriers. Effective 7/1/2016, DBHDD has implemented policy that ensures contracted community care providers of behavioral health services have a standardized process for assessing an individual's transition needs and incorporating the individual and hospital's recommended services in order to facilitate continuity of care. The Transition Action Plan (TAP) document provides the individual, and community care provider a concise document of the next steps for the individual's continued recovery and successful transition back into the community. In FY16, DBHDD transitioned more than 347 individuals with hospital lengths of stay greater than 45 days from the Adult Mental Health units.

DBHDD has Transitional Coordinators in our Regional Field Offices to help support ADA Settlement Agreement services, such as Community Support Team (CST), Crisis Respite Apartments, Assertive Community Treatment (ACT), Intensive Case Management (ICM), and Supported Employment (SE) etc. to insure timely access to services and to assure appropriate

utilization management. The goal is to have services that support individuals' recovery and allow them to move through the continuum of support services and toward greater independence.

Peer Mentors (with an individual's consent) continue to assist individuals transitioning from institutions to communities. Peer Mentors to assist individuals with identifying community resources, including medical and dental care, employment services, educational services (primarily GED services), support groups, and natural supports. Peer Mentors hold positions at all state operated hospitals.

Georgia's Olmstead Coordinator visits individuals in the state hospitals as well as individuals who have been discharged from the hospital. The Olmstead Coordinator is talking with individuals, hospital region field office staff and community care providers regarding barriers to community living for individuals who wish to receive their services in the community, and have a clinical team recommendation for transition. The Olmstead Coordinator is charged with working with individuals with disabilities, state agencies, advocates and other stakeholders in collaboration with the Olmstead Planning Committee, appointed by the Governor, to develop and implement the State's Olmstead Plan.

Available Services

Georgia's adult mental health state service system includes an array of Core, Specialty, Crisis, and Inpatient services. Adult Mental Health has invested considerable resources to ensure availability of a comprehensive array of intensive, out-of-hospital services including the development of intensive treatment residences, mobile crisis response teams, community based crisis stabilization units, assertive community treatment and community support services, intensive case management as well as psychosocial rehabilitation, peer wellness centers and a host of other community based programming all with the goal of supporting a meaningful life in the community for all of Georgia's citizens.

Consumers and family members may access services by going directly to the provider. For efficiency and convenience, consumers and family members may access statewide Core, Crisis, and Inpatient Services by contacting the Georgia Crisis Access Line. Core Services include a standardized community mental health center type benefit package of behavioral health services that most adults with mental illness would utilize to promote improved functioning and recovery. Specialty Services include those services that adults with more intensive behavioral health needs would utilize based on individual assessed need in order to successfully live in the community. For routine services, the DBHDD statewide Access/Crisis Call Center refers to Core Providers and does not provide direct access to specialty services such as ACT, CST, Residential Services, Psychosocial Rehabilitation, and Supported Employment. The crisis/access call center only refers to Core providers to ensure that individuals' needs are thoroughly assessed through Core Services prior to entering more intensive community services. Consumers have multiple points

of access to specialty services including self-referral or referral by a core provider, hospital, or crisis service. To support consumers and family members in their having full choice of services and service providers, the Department is exploring ways to make all specialty service contact information readily available in one centralized location.

Core service providers are reimbursed via Medicaid or state dollars or both to provide in clinic and out of clinic services for consumers receiving services from them. While DBHDD still contracts for services funded through state dollars, the Medicaid Rehabilitation Option was opened to additional Medicaid providers in 2007, allowing expansion of Medicaid services in all regions and expanding choice for consumers. The state utilizes contracting requirements and outcome expectations to foster implementation of the desired array of services in the system. Of note, Georgia still operates under a submitted Medicaid State Plan Amendment (SPA) that had far reaching implications for state providers. From 2008 to 2011 essentially, all services, except for ACT, were "unbundled" and each practitioner, based on practice act licensure or educational qualifications, and were grouped into one of five practitioner bands. Rates of reimbursement are based on a complex formula that takes into account productivity, Department of Community Health rates established in the SPA, license, certification or educational qualification, intensity of service and cost of doing business. Moreover, service definitions reflect incremental intervention activities (15 minutes) and define service provider minimum requirements.

Georgia had a subsequent plan approved in 2012 in which some "re-bundling" was allowed. The State Plan was expanded to add several intensive community-based services in order to be responsive to the state's Department of Justice ADA Settlement Agreement. Those services include Community Support Team (community –based, small multi-disciplinary service that operates in the most rural areas of the state), Community Residential Rehabilitation (a rehabilitative residential treatment option), and Intensive Case Management and Case Management (to replace a previous Community Support service). Additionally, the state added some new innovations to the Medicaid State Plan:

1) Peer Support Whole Health and Wellness Coaching
2) Addictive Diseases Peer Support
3) Task-Oriented Rehabilitation (which supports individuals with rehabilitative skills to get and keep work)

Crisis stabilization units, behavioral health crisis centers, mobile crisis services and assertive community treatment assist persons through acute crises while remaining in the community. Although each of the six DBHDD regions has access to psychiatric hospital services for acute inpatient care for adults requiring hospital treatment, utilization of inpatient treatment is closely monitored. Every effort is made to prevent hospitalization through increased reliance on Community Crisis Stabilization Units (CSU), Crisis (walk-in) Service Centers (CSC), Behavioral Health Crisis Centers (CSC, Temporary Observation Unit, and CSU all on the same campus),

and Crisis Respite Services. A network of Crisis Stabilization Units is spread across the state to help consumers in need of intensive interventions including; rapid assessment, stabilization, observation or brief admission. In community settings, the focus of CSU/BHCCs is provision of assessment, stabilization, medication monitoring, nursing services, linkage and referral and other treatments to support the consumer in quickly returning to their own home in the community. In FY11, House Bill 343 was passed pertaining to CSUs. This bill facilitates the entry of new providers into the CSU market in order to expand the spectrum of behavioral health services in the community and allows for the regulation of CSUs through licensure. DBHDD is now the licensing agency.

In addition, there are mobile crisis teams in all six regions. As Georgia enhances community integration options for persons living with a diagnosis of a major mental illness, mobile crisis response services fulfill an important role in stabilizing and supporting persons in crisis while assisting them in choosing the right environment to overcome that crisis. In 2013, DBHDD implemented mobile crisis services by selecting two providers through a competitive bidding process to operate crisis teams serving all 159 counties in the state.

The following services for adults with mental illness are provided statewide through a combination of state, federal and Medicaid funding:

Access and Referral Service

- Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance needs mental health crisis services. The Georgia Crisis and Access Line (GCAL) is a 24 hour/7 day a week resource for Georgians who need either routine, crisis, or inpatient behavioral health services. The system, which includes mobile crisis services in several counties, provides fast and accurate connections with on-the-spot appointment scheduling for services.

Core Services

- **Diagnostic Assessment and Individualized Recovery/Resiliency Planning** Consumers have the opportunity to meet with clinicians, physicians, nurses, peer specialists and care managers to receive comprehensive assessment, a recovery plan built to specification and consumer driven and linkage to other community-based services such as housing, employment, whole health planning and support programs. A diagnostic assessment is provided by a physician or advanced practice nurse or physician's assistant trained in psychiatry and includes a bio-psychosocial history, mental status exam, evaluation and assessment of physiological phenomena, psychiatric evaluation, screen for withdrawal if indicated, assessment of appropriateness for service or continuation of service and a disposition.

- **Crisis Intervention**
  Crisis intervention services are available 24 hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting. Services are directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior related to a precipitating situation or a marked increase in personal stress. Crisis services are time-limited and are designed to prevent out of community placement or hospitalization. Interventions are used to de-escalate the situation while facilitating access to a myriad of crisis services when deemed necessary. The individual's behavioral health care advanced directive, if existing, is utilized to help manage the crisis.
- **Psychiatric Treatment**
  Medical evaluation and medication management as well as assessment for appropriateness of treatment and monitoring an individual's status in relation to treatment and medication.

- **Nursing Assessment and Health Services**
  Typically, face to face contact with a licensed nurse who provides nursing assessments to care for physical, nutritional and psychological issues, assess response to medication, consult with consumer about medical, nutritional or health related needs, educate about potential side effects, perform venipuncture, provide assessment, testing and referral for an infectious disease.

- **Medication Administration**
  The act of introducing a drug into the body of another person by any number of routes. Medication administration requires a physician's order and is not the supervision of self-administration of medication.

- **Pharmacy Services**
  Either operate or purchase services to order, package, and distribute prescription medications. Assists consumers in accessing medication assistance programs and performs necessary lab work so that a consumer is not refused service due to inability to pay.

- **Case Management**
  This service consists of providing support, linkage and care coordination considered essential to assist the individual with improving their functioning, gaining access to necessary services and resources, and creating an environment that promotes recovery as identified in his/her individual recovery plan.

- **Psychosocial Rehabilitation- Individual**

Services include individual rehabilitative skills building considered essential in improving an individual's functioning level and learning skills that promote his/her access to necessary services and resources.

- **Individual Counseling**
  A therapeutic intervention where in a qualified clinician employs techniques to assist a person in identifying or resolving personal, vocational, intrapersonal and interpersonal concerns.

- **Family Training/Counseling**
  A therapeutic intervention with identified family populations directed toward the achievement of consumer specified goals with an anticipated outcome of restoration, development, enhancement or maintenance of processing skills, healthy coping mechanisms, adaptive skills and behaviors, interpersonal skills, family roles and relationships, family understanding of mental illness and/or substance related disorders.

- **Group Training/Counseling**
  Services provided in a group format with a skilled clinician or facilitator to address goals and issues the consumer identifies as important to his or her recovery.

Specialty Services

- **Assertive Community Treatment**
  Is a recovery focused, high intensity, community based service for individuals whose past or current response to other community-based intensive behavioral health treatment demonstrated minimal effectiveness, discharged from multiple or extended stays in psychiatric hospitals, frequently seen in emergency rooms, or crisis stabilization units due to SPMI, chronically homeless, and/or released from jails or prisons. A multidisciplinary team provides intensive, integrated and rehabilitative treatment and support within the community, and 24/7 face-to-face services must be available. This service is designed to decrease episodes of homelessness, hospitalizations, incarcerations, emergency room visits, and crisis episodes through comprehensive treatment that promotes community integration.

- **Community Support Team**
  Is an intensive community-based service for individuals in rural areas who cycle in and out of intensive services and have not had their mental health treatment needs met via traditional outpatient services. This service is designed to decrease hospitalizations, incarcerations, emergency room visits, and crisis episodes through community integration. This service includes nursing services, care coordination, individual

counseling, and skill building. Working in partnership with the core provider, this service is available 24/7 with emergency response coverage.

- **Peer Support Services/Forensic Peer Support Services**
  Provide structured activities within a peer support center, inpatient hospital, CSC/Temp Observation, correctional facility, probation reporting center, or mental health treatment court that promote socialization, recovery, wellness, self-advocacy, development of natural supports maintenance of community living skills and successful community reintegration

- **Psychosocial Rehabilitation-Group**
  Is a therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings. Services include group skills building, social problem solving and coping skill development, prevocational skills and recreational opportunities. It is offered twenty-five hours a week, for a maximum of 5 hours per Day.

- **Supported Employment**
  Job development, placement and training for individuals with behavioral health challenges who desire competitive employment and need assistance to locate, choose, obtain, learn and maintain a competitive job in an integrated setting. Services include vocational interest and skills assessment, job search, and maintenance supports that are necessary to perform and retain a particular job.

- **Intensive Case Management**
  This is a recovery focused community approach that assists individuals with complex and high intensity care coordination of service needs with moving between and among services necessary in order to remain in the community. Primary functions of this service include assessment of need, recovery planning, care coordination, access to resources, and monitoring. With a low staff to client ratio and a focus on rehabilitation, interventions are delivered primarily in the community rather than in office settings in order to coordinate needed mental health, physical health, and social services to support the consumer's recovery process.

- **Intensive Residential Services**
  Provides around the clock awake staff to assist consumers to successfully maintain housing stability within the community, continue with their recovery and increase self-sufficiency. A minimum of five hours of skills training is delivered each week to each consumer enrolled.

- **Semi-Independent Residential Services**
  The semi-independent residential service provides on-site staff available to deliver personal support and skills training at least 35 hours per week to each consumer.

- **Independent Residential Services**
  Scheduled residential services to a consumer who requires a low level of residential structure to maintain stable housing. While there must be a written emergency plan that gives consumers access to a residential service specialist 24/7, the service requires a minimum of one face to face encounter per week.

- **Housing Vouchers**
  The Georgia Housing Voucher assists individuals with an SPMI categorization in attaining and maintaining safe and affordable housing and supports their integration into the community. Supported Housing includes integrated, permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. All individuals with financial means are required to contribute a portion of their income towards their living expenses (tenant paid utilities, rent, and initial start-up expenses).

- **Projects for Assistance in Transitioning from Homelessness (PATH)**
  PATH is a SAMHSA grant funded program designed to support the delivery of outreach and case management services to individuals with serious mental illness and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH's homeless outreach teams in Atlanta, Marietta, Columbus, Augusta, Valdosta, and Savannah outreach into the streets and homeless shelters to identify people who are chronically homeless and highly vulnerable to health risks. The teams use assertive engagement strategies to help people access housing and resources needed to end their homeless cycle.

Crisis Services

- **Mobile Crisis**
  This service provides community-based face-to-face crisis response 24 hours a day, seven days a week to individuals in an active state of crisis that threatens their safety. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level.

- **Crisis Stabilization Unit**

A residential alternative to inpatient hospitalization, crisis stabilization programs offer psychiatric stabilization and detoxification services through medically monitored services to include psychiatric medical assessment, crisis assessment, support and intervention, medication administration, management and monitoring, brief individual, family or group counseling and medically monitored residential substance detoxification (ASAM level III.7-D.)

- **Behavioral Health Crisis Centers**
  BHCCs provide a community-based setting for adults experiencing a behavioral health crisis to walk in 24/7 and receive triage, evaluation, stabilization, observation, treatment and discharge planning.

- **Crisis Respite Apartments**
  Crisis respite apartments offer a brief period of respite for individuals needing a supportive environment. This service is available for individuals who are transitioning back into the community from a psychiatric inpatient facility, crisis stabilization unit (CSU) or behavioral health crisis center (BHCC)a. Crisis respite apartments include individualized engagement, connection to crisis planning, linkage to treatment, and other community resources necessary for the individual to safely reside in the community.

Inpatient Services

- **State Operated Psychiatric Hospitals**
  DBHDD maintains accredited state operated psychiatric hospitals that provide intensive inpatient services for individuals who present an "imminent danger to self or others".

- **Community Based Inpatient Psychiatric and Substance Detoxification Services**
  This is a short term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance abuse disorder. Georgia is moving away from hospital settings and toward social detoxification, assertive community treatment teams, mobile crisis response teams and crisis stabilization programs.

Substance Use Disorder Services

Substance Use Disorder treatment and recovery support services are contracted through Tier 1, Tier 2, Tier 2+ and specialty providers statewide. By contract, all providers offering the core benefit package must be co-occurring capable. Georgia provides the following service array;

- Outpatient
- Residential
- CSU crisis services

- Detoxification
- Women's Treatment and Recovery Support Services (outpatient, residential and transitional)
- HIV EIS
- Peer Support services
- Addictive Disease Support Services
- C&A Clubhouses
- C&A IRT
- Adult Recovery Centers
- Opioid Maintenance Treatment

Georgia's gender specific and age specific substance use treatment programs use evidence-based practices and fully integrates both mental health and substance use issues in the individualized recovery plan of those individuals who identify substance use as a barrier to recovery. DBHDD has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. DBHDD emphasizes that addiction specialists receive training in trauma informed care and uses the Trauma Recovery and Empowerment Model (TREM) as well as introducing Seeking Safety specifically geared toward those who have criminal justice involvement and combat induced trauma along with co-occurring disorders. In conjunction with the training needs of providers, the OAD is a board member of The Georgia School of Addiction Studies which helps providers build skills for treating substance use disorders and identifying and treating co-occurring mental illness and addictive diseases. Some scholarships for community mental health providers are available to attend the trainings that are offered.

In May 2017, DBHDD was awarded a State Targeted Response (STR) to the Opioid Crisis Grant by the Substance Abuse and Mental Health Service Administration (SAMHSA). The funding, totaling nearly $11.8 million, is provided for in the 21st Century Cures Act of 2016, and will support DBHDD and other community providers combatting opioid addiction through prevention, treatment, and recovery services. Using a targeted response to the opioid crisis in the state, Georgia's Opioid State Targeted Response project includes project activities to strengthen infrastructure, address gaps in evidence-based practices and services, and enhance the continuum of prevention and recovery-oriented treatment.

Medical and Dental Services

Consumers access medical and dental services through a variety of resources. Those qualifying for Medicaid services generally use Medicaid-approved practitioners while those without means to pay for medical and/or dental services access care through free clinics such as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Those consumers who need assistance with accessing medical and dental services are linked with appropriate resources,

including, for those who need it, community support and case management practitioners who can remind and assist consumers in meeting their medical or dental appointments.

In order to promote whole health, nurses who are a part of the DBHDD provider network provide behavioral health-centered nursing support and are also enabled through policy to monitor basic whole health elements such as:

- Providing nursing assessments and interventions to observe, monitor and care for the physical, and nutritional problems manifested in the course of the individual's treatment;
- Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the condition (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.);
- Consulting with the individual's identified family/caregiver/natural supporters about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
- Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc.); and
- Providing assessment, testing, and referral for infectious diseases.

Integration of Behavioral Health and Primary Care

Region 2 providers coordinate and partner with several community physicians, local health clinics, local physicians, dental providers and pharmacies as well as a FQHCs. For example, River Edge CSB is in partnership with the FQHC and provides staff to the FQHC which is located at their site. Case Managers assist people with linkage to physical health providers and transportation as needed. As previously mentioned, Advantage BHS is a key collaborator in a jointly initiated project unique to Athens, the Athens Resource Center for Hope. Specifically, Advantage provides outreach and support services within a co-located facility that also housed the Athens Nurses Clinic and Live Forward. Through this partnership they are able to provide collaborative case management and support services that meet the health, financial, and overall stability needs of local homeless individuals and families. In addition, Advantage BHS was awarded a direct SAMHSA grant to expand outreach, HIV education & testing, and substance abuse services to African American Women with or at risk of HIV infection. Central to this grant program, RISE Women's Wellness Program, are formal Memorandums of Agreement that outline referral and colocation activities with Advantage Partners that include Ryan White Specialty Care Clinic, Live Forward, Athens Nurses Clinic, and ACC Jail. The program allows for Advantage to embed licensed clinicians within partner agencies for the purpose of integrating primary health and behavioral health services with a "warm hand-off" model. Additionally, Advantage partners with these organizations to conduct community education and HIV testing

events. These partnerships have helped to expand Advantage's client base and bolster outreach activities to those in need.

Region 1 providers partner with medical providers in their service area. Avita CSB partners with Georgia Highlands Medical Services, Medlink, Good News at Noon and Clinic, Good Shepherd Medical Services and First Baptist Church (medicines for homeless individuals). Cobb CSB partners with the Lifeline Project for HIV, and HEP C testing and treatment. In Region 3 Grady Behavioral Health and Mercy Care's primary care and physical health have co-located services. In Region 4, the Field Office Regional Services Administrator has been working with a local FQHC, Albany Area Primary Health to partner on grant opportunities to test primary care/behavioral health models. In Region 6, Middle Flint CSB is working on a partnership with a local Healthcare agency; New Horizons CSB is a participant in the Better Life Integrated Behavioral Health/Primary care Program; and, Pathways CSB is a partner with the Good Samaritan Clinic, Your Town Health, and the Rapha Clinic. In Region 5, Gateway CSB partners with community health providers such as McKinney Community Health and Two Rivers Health. In addition, they have MOUs with Coastal Community Health, Diversity Health Center and Cutis Cooper Center. In addition, in Region 5, the CSB of Middle Georgia partners with FQHCs and health clinics in their area as well as the local county health departments on referrals, access to primary care physicians and medications. CSDBMG has licensed staff and paraprofessional staff who provide services in several pediatricians' offices on a regular basis as well. Healthy Start is a collaborative partner whose board CSBMG is on and have developed programming around the needs of the individuals they serve.

Suicide Prevention

In FY 2007, the General Assembly approved legislation to create and fund the Suicide Prevention Program to be located in the Department of Human Resources, Division of Public Health. In FY2007, 2008 and 2009 the Suicide Prevention Program was managed by the Division of Public Health. During these years, the Division of MHDDAD in the Georgia Department of Human Resources participated in the Suicide Prevention Coalition of Georgia (SPCGA), along with the Suicide Prevention Program, to plan for the implementation of key suicide prevention activities. In FY 2010, with the creation of the new Department of Behavioral Health and Developmental Disabilities, the Georgia Suicide Prevention Program moved into DBHDD with revised enabling state legislation. The Suicide Prevention Program is currently housed within the DBH Office of Prevention Services. Because of this history the Suicide Program has both a public health and a behavioral health approach.

The current DBHDD suicide prevention team is led by the Director and Assistant Director of the Office of Prevention and staffed with the state Suicide Prevention Program Coordinator, Suicide Prevention Specialist, and Garrett Lee Smith Youth Suicide Prevention Grant Director. The Suicide Prevention Program developed and provides technical assistance related to DBHDD

Policy 01-118, Suicide Prevention, Screening, Brief Intervention and Monitoring that was implemented in all Tier 1 and Tier 2+ comprehensive community provider organizations July 1, 2016. This policy provides that all consumers who present for services are screened for past and/or present suicide ideation and behavior; all consumers who screen positive are provided a jointly developed safety plan, and monitored for safety. Further, for those at risk of suicide a Suicide Risk Formulation is developed and guides the suicide specific care set forth in the care management plan. All tools used in this suicide care are evidence based and embedded in the electronic record of the provider organization. All staff are trained use the evidence-based tools before use and all provider staff are trained in suicide gatekeeper training during the on-boarding process. In addition to supporting this policy implementation, the suicide prevention team works in the community to provide education, resource information and support for loss survivor. A summary of the work of the Suicide Prevention Program is included in the Environmental Factors and Plan section.

Other System Integration

The DBHDD is heavily involved in many initiatives that coordinate mental health services within a broader system. The Department has developed memoranda of understanding and other types of partnerships with organizations including The Division of Aging Services, the Department of Human Services, the Department of Community Health, the Department of Community Affairs, the Department of Public Health, the Georgia Vocational Rehabilitation Agency, the Department of Corrections, the Department of Community Supervision, and other governmental agencies.

DBHDD and the Division of Aging Services (DAS) partnered with the Carter Center Mental Health Forum and the Centers for Disease Control and Prevention to offer a national conference on Effective Programs to Treat Depression in Older Adults: Implementation Strategies for Community Agencies – From Research to Practice. The Georgia Peer Support Institute conducted a pilot training with Certified Peer Specialists on Peer Support and whole health initiatives for older adults. DAS is a very active participant on the BHPAC and are very active partners in planning for the needs of older adults living with mental illnesses. In July 2014, DBHDD and DAS entered into an agreement with the Fuqua Center for Late-Life Depression, Emory University to strengthen Georgia's system of care for the growing older adult population with severe and persistent mental illnesses. In FY18 this agreement has been extended to include The Carter Center. A staff member from DBHDD and DAS have time committed to this work. The Georgia Coalition on Aging and Behavioral Health (GCOABH) whose membership consists of staff from DBHDD, DAS, DCH, DPH, CDC, and numerous other organizations and people interested in the needs of this population including family members and older adults, has led efforts to cross train the aging network and the public behavioral health system regarding both systems of care and how to access services. Extensive training regarding recovery in older adults, decision making capacity in persons with mental illness and dementia, and care

coordination across systems has taken place, and efforts are also underway to improve the direct care of this vulnerable population through local partnerships between aging services providers and public behavioral health service providers.

Housing and employment are two priorities for persons with mental illness that have benefited from collaboration between the mental health agency and other parts of the service system. On the employment front, the Georgia Vocational Rehabilitation Agency and DBHDD entered into a Memorandum of Understanding (MOU) to coordinate the delivery of behavioral health and vocational rehabilitation services in an effort to increase employment outcomes for individuals with serious and persistent mental illness. Throughout this collaborative work both agencies have continued to provide cross training to staff working respectively with the dually enrolled population to promote understanding on behalf of both agency's staff and ensure the vitality of the services being rendered to dually enrolled individuals. These training opportunities have allowed DBHDD to increase access to GVRA services statewide via this partnership. Both partnering agencies will continue cross-training this fall; while focusing on a statewide refresh for new and existing staff.

Regarding housing, DBHDD and the Department of Community Affairs (DCA) have a Memorandum of Understanding in which joint planning; funding requests and requests for procurements are designed to develop supportive housing opportunities and prioritize access to rental assistance programs for consumers living with mental illnesses. In FY08, the Department of Community Affairs (DCA) and DBHDD entered into a partnership to expand the housing resources for homeless individuals and those with mental health disabilities. The two Departments have been working cooperatively to establish independent, permanent supported housing programs and assist individuals in obtaining and maintaining safe, affordable housing. DCA provides many financing programs to develop housing and DBHDD provides the residential supports needed to assist people in staying in the communities of choice. DBHDD continues to strengthen partnerships that can increase the availability of permanent supported housing for those with serious and persistent mental illness who are homeless. In FY 2017, DBHDD and DCA expanded their MOU and created the Director of Supported Housing position to cooperatively advance the collective housing efforts of both agencies. In March of 2017, the Office of Adult Mental Health, created the Supported Housing Unit, under the direction of the Supported Housing Director, this unit will move forth the goals of supporting providers of both housing and residential services as well as meeting and sustaining the supported housing requirements of the Settlement Agreement Extension. This includes, increasing access to independent, permanent supported housing for our target population, maximizing state resources for supported housing for our target population, operationalizing a statewide unified referral process for supported housing, and continuing the work of oversight of the statewide supported housing need and choice survey. This unit will work in collaboration with the DBHDD and DCA regional field offices, community BH providers, hospitals, state and local agencies and law

enforcement to support comprehensive implementation of strategies that will promote supported housing access statewide.

The State of Georgia was awarded $14.4 Million from HUD to provide long-term project-based rental assistance to persons with disabilities. The HUD 811 PRA grant provides units of housing that are attached to new and existing tax-credit apartment developments around the state. The State of Georgia, through the Department of Community Affairs (DCA), has seized upon this exciting opportunity to expand its inventory of housing resources through the Section 811 PRA Demonstration Program in furtherance of its commitment to provide integrated housing opportunities with support services to extremely low income persons with disabilities and their families. The State of Georgia also received a HUD waiver to prioritize those meeting the DBHDD DOJ target population criteria for a preference Housing Choice Voucher (HCV). Through these strategic efforts, DBHDD and DCA are expanding and utilizing funding diversity and leveraging thus increasing and stabilizing housing opportunities for individuals with SPMI.

The Division of Behavioral Health continues to sustain and expand relationships with the state Department of Veterans Services, the Department of Veteran Affairs, and Veterans Administration Medical Centers due as a result of to the past award of a SAMHSA Jail Diversion and Trauma Recovery – Priority to Veterans grant. An example of this collaboration is DBHDD's training of VA CPSs on the base curriculum, as well as Whole Health, using the Whole Health Action Management training. Also, as previously mentioned the BHCC established an initiative in 2013 whereby the Transition Workgroup was developed to address the needs of persons transitioning from the correctional/justice system into the community. The Workgroup is co-chaired by the DBHDD Director of Adult Mental Health and the Department of Community Supervision Reentry Director. Early outcomes are fostering inter-agency partnerships to address barriers and infrastructure challenges for persons in the criminal justice system. DBHDD is involved in the Georgia Prison Reentry Initiative (GPRI). This collaboration brings partnering agencies together to address issues of service access and effective community transition for persons with a mental illness who are returning from the correctional system.

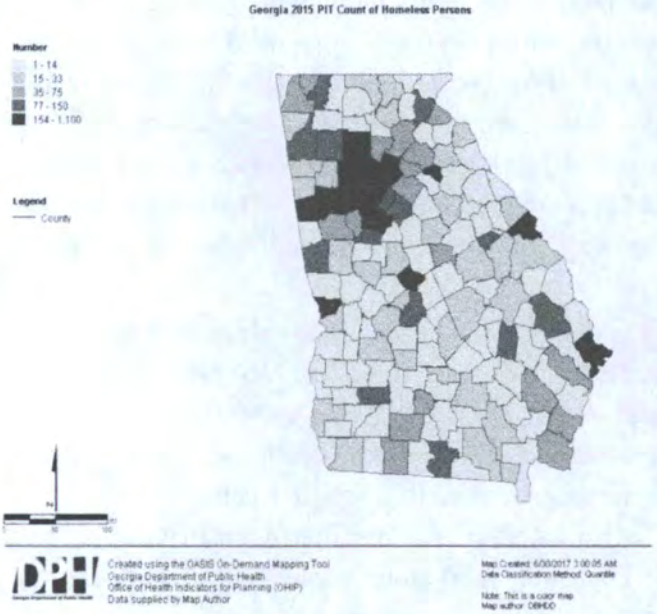
Criterion IV: Targeted Services to Rural, Homeless, Older Adults and Special Populations

Outreach to Homeless

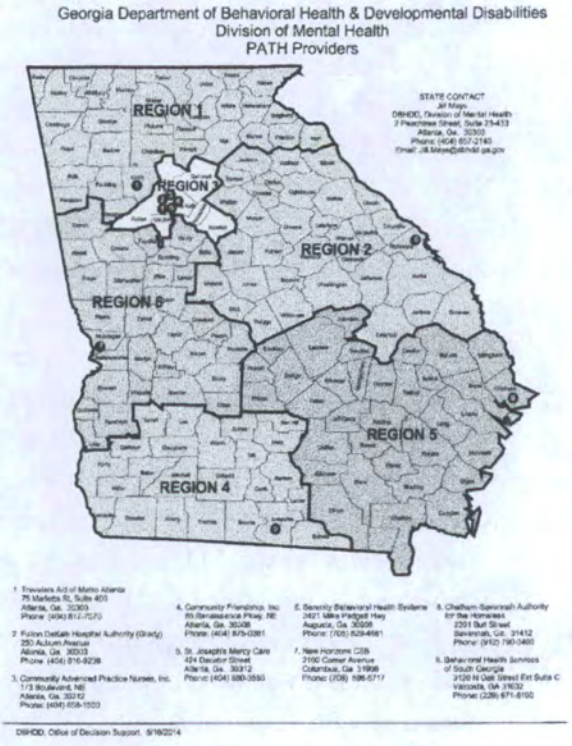
Substance Abuse and Mental Health Services Administration (SAMHSA) indicates 20% to 25% of the homeless population in the United States suffers from some form of severe mental illness. In 2018, according to the HUD Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations report of data from the January 22, 2018 Point-in -Time count, on that night in Georgia there were as many as 1,875 (24%) homeless adults with severe mental illness, and as many as 1,080 chronically homelessness persons. A comparison of the 2015 PIT Count of Homeless Persons map (Image 1) and the PATH Local Area Providers map (Image 2)

below, demonstrates that current PATH teams are located in areas of the state with the greatest number of individuals who experience homelessness with serious mental illnesses or co-occurring substance use disorders.

2015 PIT Count of Homeless Persons (Image 1)



PATH Local Area Providers by DBHDD Region (Image 2)



It is the overall goal of the Projects to Assist in Transition from Homelessness (PATH) program to effectively and efficiently reduce homelessness for individuals with mental illness who do not access traditional mental health services on their own. The primary functions of PATH program are to identify, engage, and link homeless individuals to mainstream mental health services, housing resources, and other needed community resources. The strategy of linking engaged individuals to mainstream providers rather than establishing a parallel service system for homeless consumers conserves Georgia's scarce mental health resources. The success of the transition of individuals from PATH programs to mainstream services requires a good relationship between PATH funded agencies and mainstream agencies. PATH funding supports outreach services that goes into communities to identify and engage "literally" homeless individuals who are unable or unwilling to access mainstream mental health services on their own. Georgia uses hired Consumer Practitioners with homeless experiences to share their personal story of recovery to help establish client rapport and a client commitment to change. A

large percentage of those receiving PATH services are successfully transitioned into mainstream service systems where they receive the resources necessary to end their homelessness.

DBHDD embraces the desired outcome of PATH programs to end chronic homelessness. In SFY16, a total of 3,029 homeless adults received benefits from PATH funded services, which are located in metro-Atlanta, Savannah, Columbus, Valdosta, and Augusta. Of those enrolled, 1,433 adults (88%) with serious mental illness or co-occurring disorders received ongoing community mental health services. Georgia uses outcome measures to identify the effectiveness of PATH services on ending homelessness by the percentage of those discharged from PATH that access housing and link to mainstream behavioral health services. Of the total number of individuals discharged from PATH services in FY 2015 (n=762), 23% (n=172) remained homeless but linked to mainstream behavioral health services, and 77% (n=590) accessed housing **AND** linked to mainstream behavioral health services.

It is Georgia's vision for FY16 through FY21 to increase PATH effectiveness at ending homelessness for adults with mental illness. PATH Teams use the vulnerability index survey developed by Common Ground Institute, to identify those most at risk of dying on the street within one year to mobilize action to access housing and services. PATH Teams are encouraged to directly link those chronically homeless who are identified as most "at risk" to ACT Teams. In addition to the state ACT Coordinator presenting as a resource at PATH Coalition meetings, PATH and ACT providers attend and annual combined provider Coalition meetings to build and strengthen the referral bridge between PATH and ACT. Georgia's PATH Program attributes its effectiveness to active state monitoring and provision of TA/training, the development of PATH Provider Quality Improvement Plans, and prioritizing the use of Outreach and Case Management services.

The PATH Training Summit took place June 18 – 19, 2019 at James Rainwater Conference Center in Valdosta, GA. This year's theme was: "Housing Beyond the Key" Ending Homelessness for Georgians with Mental Illnesses! This conference was presented by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Adult Mental Health and funded in part through SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) grant.

The 2019 PATH Training Summit focused on effective strategies and resources for service delivery, including 1) Homeless Management Information System (HMIS) 2) HUD Coordinated Entry, 3) Deeper understanding of mental illness and its implications for homelessness, 4) spirituality and recovery 5) Homeless Service Project, and 6) PATH teams in review. Speakers will include subject matter experts. Providers from all across the state came to Valdosta, GA this June to learn about what is working, shared successes, and to meet others who are diligently

working to end homelessness in Georgia. All staff paid using PATH funds were required to attend.
Attendees received the following:

- Reviewed HMIS and PATH data requirements.
- Learned about best practices from the field to assure that individuals with serious mental illness have easy access to supported housing and community behavioral health services.
- Participated in a learning environment where providers can share their energy and experience in driving down homelessness in their community and learn from the experts across the service continuum who are making it happen.
- Identified appropriate resources and potential collaborations in their communities to assist people experiencing homelessness.
- Identified how having a spiritual connection helps build recovery and hope.
- Had fun learning in a relaxed, interactive environment!

According to DBHDD data for 2016, 5,948 homeless persons accessed mental health services (5,851 adults; 97 children). Georgia is committed to ending homelessness by implementing strategies that increase access to permanent housing and mainstream services for chronically homeless individuals and families with severe mental illness.

In partnership with the Department of Community Affairs (DCA), DBHDD works with core providers to identify target populations and areas of the state in need of Shelter plus Care housing. DBHDD also helps to establish supportive housing using Housing Choice and 811 Program vouchers and attaching mental health services and supports for those individuals who choose them. This has been an effective collaboration that helps consumers who are homeless to access safe, decent and affordable housing and receive community-based recovery services.

The costs of homelessness are great for individuals as well as for states and communities. Estimates of up to $4 billion is spent annually on homelessness by local and state governments, health care providers, correctional facilities, emergency shelters, and other providers of services to people who are homeless. Social Security Administration oversees Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefit programs for people with physical and/or mental disabilities. For people with disabilities who are homeless, the immediate gains of SSI and SSDI are clear; a steady income and health insurance. Despite the benefits to individuals and communities, an estimated two-thirds of people who are chronically homeless and have mental illness do not receive SSA disability benefits. Many likely would be eligible for SSA benefits; however, in Georgia only 20 percent of those who apply are approved upon initial application.

DBHDD supported a SOAR Demonstration Project between 2007-2011 to demonstrate increased access to SSI/SSDI for mentally ill adults experiencing homelessness; and to teach others how to

use SOAR techniques to dramatically expedite the application process and reduce the disability determination period. In 2013, DBHDD entered into a formal agreement with the Department of Community Health (DCH) to hire six (6) Medicaid Eligibility Specialists (MES) to actively assist individuals coming out of state hospitals with accessing Medicaid/Medicare. As of 2016, there are now 9 full time MESs. All MESs have consistently maintained In FY15, 220 applications were approval at rates of 85-89%. DBHDD continues to provide SOAR training using SAMHSA's curriculum to contracted providers throughout the state. Training dates for 2019, so far, were January 15th and 16th, February 11th and 12th, March 28th and 29th, April 11th and 12th, May 15th and 16th, June 4th and 5th, July 25th and 26th, and August 15th and 16th, 2019.

DBHDD Field Offices and providers are engaged in local communities with planning for and provision of services to homeless individuals. Below are some highlights of the regional activities.

The Region 1 Field Office staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participated in other provider and stakeholder meetings/coalitions to address the needs of homeless individuals. These have included meetings with: Unify North Georgia; Highland Rivers Health (CSB) with Floyd Care Transition Team, The William Davies Homeless Shelter, and the Salvation Army Shelter; Avita CSB with Action Ministries, Joe's Place, Set Free Ministries, Baptist Mission in Gainesville, Gainesville Connection (free bus passes for homeless to get to appointments), Chattahoochee Baptist Association, and Salvation Army Shelter Gainesville; and, the Cobb CSB with MUST Ministries for Homeless. In addition, all ACT Teams in the region have relationships and conduct outreach to shelters throughout the region.

The Region 2 Field Office staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participated in other provider and stakeholder meetings, such as the COCs in their region. In addition, the providers screen individuals for homelessness and make housing available as appropriate in Shelter Plus Care or the GHVP. One of the providers also has a formal partnership with a day service center for homeless individuals. The PATH team provides outreach and is a good resource for homeless shelters in one of the provider areas. Another provider is a collaborator with the Athens Resource Center for Hope. This Center includes formal partnerships among Advantage Behavioral Health Systems, Athens Nurses Clinic, Live Forward (Formerly AIDS Athens), Athens Area Homeless Shelter, and Little Angels Daycare. Specifically, Advantage BHS provides outreach and support services within a co-located facility that also houses the Athens Nurses Clinic and Live Forward. Advantage BHS created the Advantage Homeless Day Service Center (HDSC) which serves as the entry point for homeless individuals into our local homeless continuum of care. The Center provides laundry & shower facilities, facilitates support groups, serves as a mailing address, offers case management,

advocacy, linkage to care, and housing assistance to individuals and families living in a homeless situation. The HDSC is the central component to the Athens Resource Center and provides coordinated assessment to individuals coming off of the street in order to assist them in accessing the support the need in overcoming barriers to housing stability. Advantage BHS also participates in the Northeast Georgia Homeless & Poverty Coalition which is the local networking and planning body that determines local needs and prioritizes services geared toward alleviating homelessness within the Athens-Clarke County Metro Area.

The Region 3 Field Office staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participate in other provider and stakeholder partnerships such as work with the Atlanta Continuum of Care (COC), the agency focused on gaining housing for homeless people, to identify and link homeless individuals, including women and children, to behavioral health providers. The staff also respond to calls from women shelters as well as domestic violence shelters asking for assistance in locating housing and Behavioral Health providers. If the individual meets criteria, the staff link them with one of the state funded providers to complete the Georgia Housing Voucher Program (GHVP) application. The PATH teams have also placed women with children into the GHVP.

The Region 4 Field Office staff facilitates 5 Regional Community Collaboratives quarterly. These meetings are attended by members of the Homeless Coalitions and their partners, such as NAMI, law enforcement, etc. They are also well attended by local hospitals who have homeless individuals in and out of their emergency rooms. In addition, the Regional Transition Coordinator participates in Homeless Coalition meetings throughout the region and attends local Department of Community Affairs meetings (state housing authority).

In Region 5, the Regional Community Collaboratives (RCCs) address homeless issues and concerns. RCCs include membership from the Salvation Army, Union Mission, Homeless Authority, United Way, Family Connection, shelters and faith-based homeless service providers to name a few. A particular area of interest for the RCCs is housing. In the Unison CSB area, Coffee and Ware County both have committees that address the homeless population. A Community Development Block Grant is being sought by the County Commissioners to build an Emergency Homeless Shelter with wrap around agencies to provide services. The FQHC is a partner in Coffee County and work with Unison on the needs of referred individuals.

In the Gateway CSB service area, Gateway works with a shelter for abused women and offers a peer program on site at the Grace House, which is a homeless shelter for 90 men. In addition, the agency participates in a homeless coalition which has community collaborators from Law enforcement, other providers, government officials and child welfare. Gateway also participates in a Coordinated Entry Planning Meeting with DCA, Shelter Plus, Gateway BHS (Liberty), Homeless Prevention, United Way, Veterans Administration (Hinesville), Diversity Health

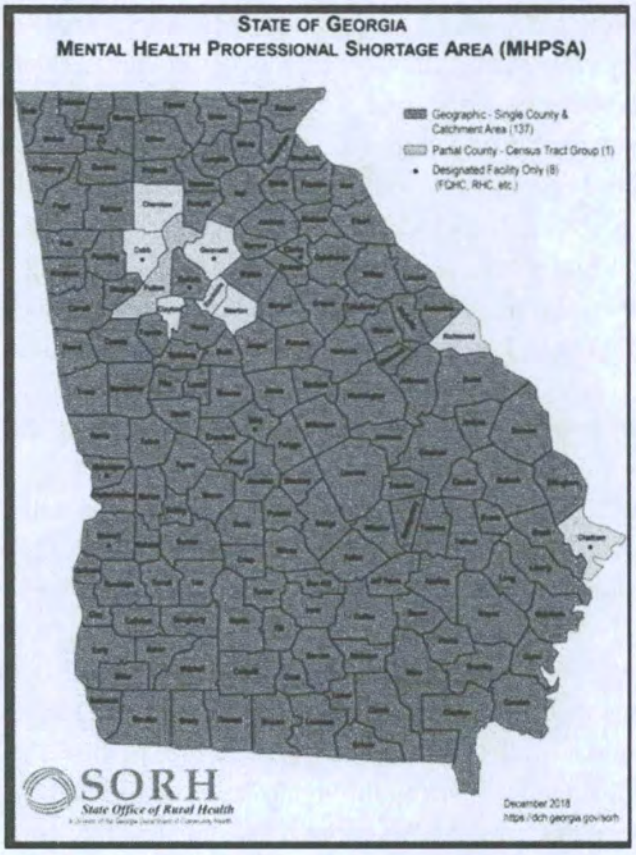
Center, Family Connection (Liberty/Long/Bryan) GA Dept. of Labor, Fraser Center, Department of Juvenile Justice (Liberty County), The Liberty County Homeless Coalition, and the Liberty County Re-Entry Coalition, Inc. Gateway also works with the Savannah-Chatman Homeless Authority, Glynn County Homeless Authority and FQHCs in their service area. The Community Service Board of Middle Georgia works with a homeless provider to solicit resources needed and has specifically supported food drives within the community. CSBMG is an active participant in the GA Housing Voucher Program and Housing First as well. CSBMG also offers Shelter Plus Care through funding received. The Pineland CSB has Shelter Plus Care, Ga Housing Voucher, and Bridge Funding. Currently they have 3 households with women and their children in their Shelter Plus Care Services. From 5/1/16 to 4/30/17 Shelter Plus Care served 53 adults and 14 children totaling 67 individuals. Pineland currently has 22 units in production housing 25 adults and 6 children (22 individuals and 3 families). Pineland 's Community Collaborative includes the Housing Authority Directors and the Director of a new local homeless shelter.

The Region 6 staff have hosted Regional Community Collaboratives and Crisis Continuum Meetings and participate in various other coalitions focused on the needs of homeless individuals and provide services that support the needs of homeless individuals. American Work participates in the GHVP and has an ACT Team that provides linkage for housing through case management. The agency also participates in several community collaboratives: Stewart Community home, Home for Good Committee, Homeless Network Collaboration and Mental Health and Veterans Courts. McIntosh Trail CSB participates in the GHVP, provides ACT and Case Management and linkage for housing through case management. This agency also participates in Mental Health Court. Middle Flint CSB and New Horizons CSB have Shelter Plus Care and the GHVP as well as Intensive Case Management services which provide linkage for housing. Pathways CSB has Shelter Plus Care and participates in the GHVP. They also provide ACT and case management services to provide linkage for housing resources. They reach out to local shelters and participate in the Homeless Coalition and Aging Collaborative. Phoenix Center has partnerships with the local Housing Authority, the Salvation Army Shelter and Safe House and participates in the GHVP as well as provides case management through Community Support Teams. In addition, they partner with: Family Promise of Greater Houston County, MH Accountability Court of Houston County, and Community Action Agencies.

Rural Area Services

DBHDD contracts with providers to cover all areas of the state. The Georgia Crisis and Access Line (GCAL) provides people seeking behavioral health services with information and access to comprehensive outpatient and crisis services throughout the state. A challenge to service provision in some areas of the state is a behavioral health professional workforce shortage. In many counties, there are few to no licensed behavioral health practitioners, and DBHDD is often in competition with other agencies and organizations for these critical staff. Georgia's Mental

Health Professional Shortage Areas continue to expand where now 150 of 159 counties are MHPSAs, as per the figure below:



One example of a service challenge is ACT. ACT is currently available in each region of the state; however, it is difficult to support an ACT team in rural areas due to dispersed populations and professional workforce shortages. DBHDD worked with the State Medicaid Authority to add a rural modifier to ACT to promote statewide expansion of ACT-type services. Therefore, DBHDD offers Community Support Teams (CST) to individuals living in rural areas. CST is led by a licensed clinician, includes a Registered Nurse, case manager, and Certified Peer Specialist.

Georgia continues to heavily invest in its Certified Peer Specialist workforce to promote recovery-based support capacity. In order to promote access, DBHDD has expanded CPS certification courses from metro Atlanta to the southern part of the state to promote rural workforce expansion. In 2019, DBHDD completed a database for all CPSs in order to map their locations and begin working toward geo-mapping to understand the capacity in rural areas. Additionally, the majority of peer wellness centers are located in rural communities and there are peer warm lines that operate 24/7. This is in addition to the GCAL which also operates 24/7 providing access to clinicians. Peer specialists continue to infuse recovery into the service system and into the lives of individuals served as well as to provide much-needed goal-advancement during gaps between visits with licensed practitioners.

Another challenge is transportation to services. In some parts of Georgia, transportation is a serious problem. Medicaid enrolled individuals are able to utilize Medicaid transportation systems for travel to services; however, transportation services remain a challenge in more rural areas. Because many individuals with behavioral health needs lack access to natural supports to assist them in traveling to services many miles away from their homes, funding for transportation to Settlement services was approved by State legislators as a part of the original Department of Justice ADA Settlement Agreement. DBHDD has entered into a contract with the Department of Human Services to provide state supported transportation for individuals receiving the intensive community adult mental health services including: ACT, CST, CSU, ICM, CM, and Supported Employment services.

The Medicaid State Plan approved in May 2017 includes a new Consultation code approval to allow Tier I and Tier II BH Providers to bill when they engage with practitioners external to the system. The goal of the service is to allow these providers to access external and remote medical professionals to 1) promote health integration and 2) to access remote medical specialists to support and or refine diagnosis, prescribing, and treatment. This will assist rural providers in accessing specialists in other communities to support the individuals in those rural areas.

Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care.

Georgia maintains and is growing the following approaches to telemedicine:

- The state continues to use teleconferencing for clinical supervision and discharge planning purposes in its state facilities;
- Teleconferencing can be utilized for the provision of Community Transition Planning, a transition support services which provides support services to individuals in the last few days of a facility admission, promoting post-inpatient community engagement;
- Georgia's Medicaid State Plan continues multiple service definitions which allow telemedicine (traditional services such as Physician Assessment, Diagnostic Assessment). In 2017, telemedicine capacity was expanded to allow non-English speaking individuals to access a same-language speaking practitioner via telemedicine for any Core and most Specialty services.
- There are over 60 DBHDD provider sites that are participating in the Global Partnership for TeleHealth [http://www.gatelehealth.org/about/partnerslocations/]. All state hospitals are telemedicine enabled.
- Both of the DBHDD's Mobile Crisis vendors have telemedicine capacity.
- Approximately a dozen more private and non-profit affiliated vendors are telemedicine enabled.

- DBHDD provided telemedicine capacity grants to XX # of youth mental health providers for youth behavioral health services and 12 Community Service Boards specific to ASD services expansion.

DBHDD continues its telemedicine interactions to promote quality stabilization, treatment, and transition. The DBHDD policy focuses on three key interaction areas:

- Telemedicine between DBHDD facilities and/or offices
- Telemedicine between DBHDD facilities and other medical facilities, for example:
  - ✓ Consultation with Emergency Departments or Crisis Stabilization Programs regarding referral for admission
  - ✓ Medical care consultation from specialists
- Telemedicine between DBHDD facilities and community entities, for example:
  - ✓ Discharge planning with Community Providers of behavioral health or developmental disabilities services
  - ✓ Sheriff Departments
  - ✓ Civil commitment hearings

Older Adults

In Georgia, the older adult population (age 60+) is projected to grow by more than 1 million people, totaling more than 2.5 million in 2030 (Administration on Aging, 2012). The National Institute of Mental Health estimates 19.8% of older adults in the U.S. have a diagnosable mental disorder during a 1-year period, which can create functional impairment, poorer health outcomes, and even increased rates of mortality (U.S. Department of Health and Human Services, 1999). In Georgia, this translates to 294,000 older adults per one-year period with a diagnosable mental disorder.

The Mental Health needs of older persons have received increased attention through the state's participation in 1) the National Governors Association Policy Academy - **Rebalancing Long-Term Care Systems Toward Quality Community Living and Healthy Aging,** and 2) the Centers for Disease Control Prevention Research Center's (CDC) Healthy Aging Network. The DBHDD Community MH Services Director and the Director of the Division of Aging Services (DAS) both served as members of the state team to develop plans to improve access to all services needed by older adults in Georgia and helped establish Georgia's network of Aging and Disability Resource Connections to serve as an entry way to long-term care support services for individuals with disabilities and the elderly. The goal for mental health improvement is to enhance the coordination and delivery of mental health services for older adults as it relates to the screening, referral, and treatment of mood disorders, primarily depression, as well as anxiety and co-occurring disorders. This will include the development of treatment protocols, reliance on evidenced based programs, wellness and improved collaboration between state services and primary care and/or family practice physicians.

DBHDD participates in the Georgia Coalition on Older Adults and Behavioral Health (GCOABH). In 2014, DBHDD partnered with DAS, the Fuqua Center for Late Life Depression, and Highland Rivers Health at the Rosalyn Carter Georgia Mental Health Forum in advancing actions regarding effective programs and policies to address behavioral health issues in older adults. Additionally, one of the members on the Behavioral Health Planning and Advisory Council works for DAS in order to ensure that older adult issues are well represented.

The Georgia Mental Health Consumer Network, the Fuqua Center for Late Life Depression, the DAS, and DBHDD partnered to develop a curriculum and trained Peer Specialists to work with older adults with mental illness on whole-health goals and activities. A demonstration training for Certified Peer Specialists in working with older adults on whole- health activities was conducted as a result of the TTI SAMHSA grant. Training was provided in to increase the number of Peer Specialists who can support and provide services to older adults. This was accomplished by partnering with primary care settings that serve a significant older adult population. Other significant collaborations have included elder abuse prevention efforts, suicide prevention, and the use of chronic disease self-management programs to enable individuals to remain as independent as possible in the community. State training related to "Mental Health First Aid" has been completed for DAS adult protective service workers and long-term care ombudsman.

The Department of Community Health (DCH) utilizes a network of DBHDD behavioral health providers to deliver mental health services to nursing facility applicants and residents authorized through the Pre-Admission Screening and Resident Review (PASRR) Program. This brought DBHDD providers into the geriatric services market and, thus, encouraged development of expertise and capacity. Many of these same providers also deliver various home and community-based services to individuals in the Medicaid Community Care Services Program who otherwise need institutional care in a nursing facility and who qualify or potentially qualify for Medicaid. DBHDD administers the L2 for PASRR through its ASO vendor and closely partners in the timely access to behavioral health nursing facility services with the DCH.

Currently, DBHDD has a Memorandum of Understanding with The Carter Center and the Fuqua Center for Late-Life Depression/Department of Psychiatry and Behavioral Sciences of Emory University to facilitate ongoing cross training of staff at DBHDD, its contracted behavioral health treatment providers, and DAS network of aging services providers in order to strengthen the existing system of care that serves older adults who have a mental illness or co-occurring disorder. Work guided by the MOU includes identification of unmet needs of this population and the development of applicable processes aimed at improving the state's capacity to care for Older Adults with Mental Illness. Initiatives include training on Evidenced-Based Practices (EBPs), development of partnerships through involvement in Coalitions and other collaborative

efforts, opportunities for gaining understanding on services available and how they are accessed as well as Policy development to address barriers that impact access to care. To date cross-training events have included:

Date	Event	Content
January 2015	GA Behavioral Health Planning & Advisory Council	• Introduction To DBHDD/DAS/Fuqua Partnership for Building A System of Care for Serving Older Adults with Mental Illness • Overview of the ARDC
June 2015	ADRC Healthy Communities Conference	*Building Capacity to Care for Older Adults with Mental Illness* • Welcome and Brief Overview of Collaborative Work • Introduction of Concept of Recovery and Older Adults with Mental Illness • Overview of Public Mental Health System Services and Access to Care • Case Studies Including Group Discussion on Challenges and Practical Ways to Work Together to Take Care of Older Adult Clients
July 2015	GA Association of Community Care Providers (GACCP) Conference	*Building Capacity to Care for Older Adults with Mental Illness* • Overview of Services Available to Older Adults: GA Crisis & Access Line (GCAL); Mobile Crisis; Statewide Core & Specialty MH Services
August 2015	Georgia Gerontology Society (GGS) Conference	*Building Capacity to Care for Older Adults with Mental Illness- 2 PARTS* PART I (One Hour) •Introduction of Concept of Recovery and Older Adults with Mental Illness •Overview of Public Mental Health System Services and Access to Care PART II (One Hour)

		•Case Studies including Group Discussion on Challenges and Practical Ways to Work Together to take Care of Clients
September 2015	ARC Atlanta Area Agency on Aging	*Building a Behavioral Health Team That Best Serves the Older Adult*
October 2015	DBHDD 2015 Behavioral Health Symposium	*Building Capacity to Care for Older Adults with Mental Illness* • Concept of Recovery in Older Adults (Kimberly Williams MHA-NYC) • Dementia 101 (Monica Parker, MD) • How to assess and appropriate services for people with dementia and SPMI (Larry Tune, MD) • Decision-Making Capacity: Legal and Clinical Considerations/Tool Kit (Dr. Jason Shillerstrom) • Overview: Evidence-Based Treatment for Older Adults (TBD) • Case Studies: Treatment and Service Options for Older Adults within the Public BH System
February 2016	NCOA Center for Health Aging webinar	*Achieving Collaboration Between Mental Health and Aging Services through Coalition Building*
June 2016	ADRC Healthy Aging Conference	*Strengthening the System of Care through Collaboration*
April – December 2016	• April—Three Rivers AAA & DBHDD Region 6 Providers • May—Heart of Georgia AAA & DBHDD Region 5 Providers • June—Atlanta Region AAA & DBHDD Region 3 & 6 Providers • Legacy Link AAA & DBHDD Region 1 Providers	*Regional Strengthening the System of Care through Collaboration Cross-training Workshops*

	• December--SOWEGA AAA, Adult Protective Services & DBHDD Region 4 Providers • December--CSRA AAA, APS, & DBHDD Region 2 Providers	
October 2016	DBHDD 2016 Behavioral Health Symposium	*(1) Care Coordination is the Key to Success-Knowing Your Aging Services Partners* *(2) Billing Medicare in a Fee-For-Service Environment.* Focus was given on helping BH providers who serve Georgia's growing population of older adults with Serious and Persistent Mental Illness work with Aging Services' providers of home and community based long-term care to understand payment mechanisms for services needed by older adults. A representative from the Center for Medicaid and Medicare provided an overview of Medicare billable services relevant to behavioral health providers. The session also provided an overview of home and community support services provided by Georgia's Long-Term Care Medicaid Waivers: Community Care Services Program (CCSP) and SOURCE, as well as services funded through the Older American's Act.
June 2017	2017 ADRC Healthy Aging Summit in Augusta	*Collaboration between Area Agencies on Aging and Behavioral Health Providers: A Recipe for Success in Serving Complex Cases*
June 2017	Evergreen Stone Mountain Conference Center	*Leadership Summit*-- updated AAA and CSB leaders about the work done to date to strengthen Georgia's capacity to care for older adults who have a mental illness, showcasing innovation partnerships

		that have taken place between several AAAs and CSBs around the state in regions where training forums have occurred, as well as to share and discuss data prepared by DBHDD relevant to service provision by CSBs to older adults
Scheduled: October 2017	DBHDD 2017 Behavioral Health Symposium	• *Evaluation of Dementia in People Who Have Severe and Persistent Mental Illness* • *Collaboration between Area Agencies on Aging and Behavioral Health Providers: A Recipe for Success*

Veterans Initiatives

Since September 2008, DBHDD's Division of Mental Health has been working diligently on creating initiatives that will have an impact on our Veterans. As one of the largest states in the U.S. with an expanding population of Veterans, Georgia is developing an infrastructure of competence in serving the needs of returning veterans. According to the US Census Bureau Quick Facts, there were 646,350 Veterans in Georgia between 2013-2017. With the large number of Veterans in the state, there is a need to address issues facing these Veterans and their families, and also a need to train interfacing agencies on how to be effective with this population.

In FY18 GA PATH Teams served 123 known homeless veterans, 4.8% of individuals served by the program. All PATH providers must demonstrate work experience and background in working with veterans. Mental Health America and the Department of Veterans Affairs estimate that 25-40% of all adult males who are homeless are veterans. According to the Georgia Department of Community Affairs 2015 Report on Homelessness, 12% of the state's homeless population are veterans. A 2012 Metro Atlanta Veterans Services Report that examined the quality and quantity of services available to Veterans in the Metro Atlanta area highlights the challenges faced by the state's Veterans. A total of 92 surveys (64% response rate) were completed by national and local nonprofits in a 10-county metro Atlanta area that provided services for Veterans. Approximately 82% of survey respondents working with Veterans believed that homelessness was a major problem in the veteran community. The major causes of homelessness cited by respondents included mental health disorders, substance abuse issues, and overall economic conditions (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012).

Approximately 75% of the 90 veterans surveyed in the above study reported known mental or physical health issues. About 58% had either a mental or physical disability. Approximately 32% of the disabled veteran respondents indicated they had a mental disability. Almost 29% of survey respondents had physical or mental health issues resulting from combat. Thirty-two percent of

the veteran respondents who had been or were currently homeless after military service indicated that substance abuse was the cause of their homelessness, but less than 4% had sought substance abuse treatment services. (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012)

PATH Outreach Teams identify, assess, link, and support homeless veterans who have a serious mental illness. Outreach staff collaborate with case managers from the Veterans Administration to engage homeless veterans in services, including regularly scheduled combined outreach activities. During these special outreach efforts all identified Veterans who agree to accept services are placed in VA Domiciliary emergency shelter and assisted in accessing all VA and other benefits they are eligible for. Regional gatherings of PATH providers and VA providers have resulted in greater collaboration to serve homeless veterans. For example, the New Horizon PATH Team has an annual homeless outreach event, with several vendor booths manned by VA and other veteran-serving agencies in the Columbus area. The Serenity PATH Team in Augusta hosts a similar event. During routine PATH site visits, providers are reminded of the special consideration regarding veterans as specified in Section 522 (d) of the Public Health Service Act.

PATH Staff are well-trained in military culture, PTSD, suicide prevention, and other topics needed to work effectively with homeless veterans. In FY 2014, PATH providers had the opportunity to participate in a statewide training curriculum, in cooperation with the CA BHI State Supplement grant staff, specifically designed to increase skills and knowledge in addressing the needs of Veterans and military families, with much emphasis on serving homeless veterans with PTSD and other trauma-related illnesses. In SFY19, PATH teams had the opportunity to participate in Georgia's statewide veterans care conference, Unspoken Wounds. Several workshops focused on strategies to assist homeless veterans in finding permanent supportive housing, employment, mainstream and VA benefits, and behavioral health treatment and support services. In the past, DBHDD has also provided funding and support for Georgia's Star Behavioral Health Providers (SBHP), a training, dissemination and referral system aimed at expanding access to trained behavioral health providers for service members, veterans and their families. PATH Teams are offered two levels of training, with course content created by the Center for Deployment Psychology (CDP) that can assist them in working effectively with veterans:

- Tier One introduces military culture and information about the deployment cycle. Open to all service providers and community members.
- Tier Two provides education about specific challenges and difficulties that are often associated with military service. Open to all service providers who have attended Tier One.

The National Coalition for Homeless Veterans (NCHV) is the resource and technical assistance center for a national network of community-based service providers and local, state and federal

agencies that provide emergency and supportive housing, food, health services, job training and placement assistance, legal aid and case management support for hundreds of thousands of homeless veterans each year. The New Horizons PATH Team is a member of this Coalition, as are several of the agencies that PATH Teams partner with for housing and support services for individuals receiving PATH case management and housing support services, including Action Ministries, Gateway Center, Hope House, Decatur Cooperative Ministries, and the Salvation Army.

In 2012, Atlanta Mayor Kasim Reed signed on to President Obama's White House Mayor's Challenge to End Veterans Homelessness in 2012. As part of a national campaign with 14 cities, Atlanta not only exceeded the goal of re-housing 100 chronically homeless veterans in 100 days, but also housed more homeless veterans than any other city as part of this challenge in the United States. On May 20, 2015 Mayor Reed announced that the City of Atlanta had made significant progress in its effort to move all homeless veterans into permanent supportive housing, putting the city on a path to meet President Obama's goal of ending veteran homelessness across the country by 2015. The City of Atlanta Continuum-of-Care continues to work with federal, state and regional partners, including DBHDD and its Region 3 PATH Teams on campaigns to house veterans.

In December of 2016 DeKalb County Continuum of Care officials announced that DeKalb is the first county in Georgia to achieve "functional zero" for veteran homelessness, meaning any homeless veteran who will accept housing will receive it. According to The Atlanta Journal and Constitution (December 11, 2016) by September of 2016, 378 veterans were placed in permanent housing through the distribution of federal supportive housing vouchers and connecting veterans to other programs. Homeless veterans with SMI may also apply for DBHDD's permanent supportive housing option, the Georgia Housing Voucher Program with assistance directly from a PATH Team or through a DBHDD-contracted Comprehensive Community Provider. Through a five-year SAMHSA grant, Georgia had the opportunity to enhance service provider, law enforcement and criminal justice knowledge of working with Veterans. In 2008, Georgia was awarded the Jail Diversion and Trauma Recovery (JDTR) Priority to Veterans SAMHSA grant to develop a statewide infrastructure for Veterans involved in the criminal justice system that have been assessed with Post Traumatic Stress Disorder and to identify best practices for jail diversion programs and trauma informed care. The original pilot site for the grant was located in DeKalb County at the DeKalb Community Service Board and relocated to Savannah/Chatham County at the Gateway Community Service Board in FY10. An additional expansion site was started at Highland Rivers Health Community Service Board in the Appalachian Judicial Circuit (Fannin, Gilmer, and Pickens Counties) in FY13. Georgia served 180 individuals in the JDTR program. This project was staffed by a state Project Director and five local staff. General oversight and strategic planning were provided by a State Advisory Council made up of State agency representatives, VA, service provides, judges, law enforcement, and veteran consumers,

as well as two (2) Local Advisory Councils of similar representation. The local demonstration sites used Seeking Safety, an evidenced-based model of treatment for PTSD and Substance Abuse. Case management was provided to support those enrolled in the program by linking them to community resources and wrap-around services that addressed their recovery and reintegration needs. With the inception of Jail Diversion Programs for Veterans, Veterans Courts, and numerous Veterans Services Organizations, Georgia is highly engaged in meeting the needs of today's Veterans and their families.

DBHDD provided an extensive array of training opportunities through this grant to promote best practices for jail diversion programs and trauma informed care. From 2010 to September 2014, DBHDD offered a plethora of trainings, designed to further equip the state's workforce. Through its rollout of regional trainings for providers, DBHDD trained over 600 practitioners, supervisors, administrators, and consumer advocates across the state.

Trainings included:

- Trauma-Informed Care for Georgia Crisis Intervention Teams (CIT)
- Trauma-Informed Care for Veterans, Clinical Perspectives Related to Jail Diversion and Trauma Recovery
- Understanding Trauma Series
    - Understanding Trauma: There's Hope in Crisis
    - Understanding Trauma: Responding with Respect
    - Understanding Trauma: Empowerment through Reintegration
- Seeking Safety: A Model for Trauma and Substance Abuse
- Clinician Administered PTSD Scale (CAPS) Training
- Vet-to-Vet Peer Support Training
- Cultural Diversity
- In partnership with the Division of Addictive Diseases, sponsored a "Paving the Way Home: event for veterans, providers, state and federal agencies, and the VA
    - Military Culture & Terminology (STAR Behavioral Health Providers—DBHDD in partnership with the GA National Guard, Emory University BraveHeart Program, the Center for Deployment Psychology, Uniformed Services University of the Health Sciences, and the Military Family Research Institute at Purdue University

A 3-day statewide conference—Unspoken Wounds: One Team. One Battle. Many Victories!! Was held March 17-19, 2019 to promote a comprehensive system of care that addresses the treatment, case management, and reintegration needs of veterans and their families. The conference was attended by more than 300 individuals and was considered to be a huge success. In open-ended responses on conference evaluation forms, participants provided praise for the conference presentations. One participant noted the expansive content options, which provided

"an opportunity to crosswalk and integrate new and existing information together," while another indicated they were "so impressed by the amount and variety of topics." Participants also stated the "presenters were better than expected" and the "organizers did an outstanding job." One attendee stated, "I have been to quite a few conferences this year and this conference stands out as one of the best. It was very apparent that the presenters are very passionate about serving those members of society who have paid the ultimate price in order to serve us. The information presented was interesting and informative." DBHDD has been able to sustain this training post-grant period utilizing state funds. Sessions included:

1. Entrepreneurship for Transitioning Warriors
2. Career Coaching for Veterans
3. Beyond Loss: Myths, Strategies & Tools to Move from Grief to Growth
4. In the Middle of Nowhere: Rural Mental Health Services for Veterans
5. Supporting Military Women Through their Transitions from Soldier to Civilian
6. Veteran Peer Workforce: The Importance of Shared Experience in Recovery Intervention
7. Beyond the Office Walls: How alternative therapies help heal
8. Military Moral Injury (Part1): Standardized Assessment Tools and Identification of What is Lost
9. Military Moral Injury (part 2): Treatment Interventions and Coordinating Community Approaches
10. Re-entry: From In-reach to Outreach
11. Treating PTSD in Veterans using an IOP Model (IOP)
12. Warrior 2 Citizen: Home Life Transition Program (HLTP)
13. Co-occurring Disorders and the Homeless Veterans: Practical Solutions for Housing and Treatment
14. Saving Shelter Dogs, Supporting Trainers
15. Reclaiming Serenity Thru Mind-Body Practices: QiGong, Zero Balancing, CBCT® Meditation and Reiki
16. Assisted Outpatient Treatment (AOT) laws in GA
17. Emotional Hygiene: Making Self-Care Non-Negotiable
18. Healing, Health and Wellness: Gentle Yoga, Mindfulness and Meditation
19. Current Challenges and Future Directions Supporting Veterans After Military Sexual Trauma
20. Strengthening Partnering Experiences
21. Transitioning through Trauma: Strategies for supporting Veterans in higher education
22. Green Zone, Understanding the Military Member
23. Triple Win: Serving Veterans, Saving Shelter Dogs, Supporting Trainers
24. Trauma Informed Care for Veterans
25. Using Social Media to build Women Veteran Communities

26. Why Wait for a Crisis?: Getting Veterans into Community Treatment Through Deflection
27. Community Impacts of Veteran Treatment Court programs
28. Sierra Club Military Outdoor: Healing through the Outdoors
29. The Warriors Journey
30. Music Therapy: Why It is a Crucial Part of a Victorious Treatment Team
31. The Journey from Trauma to Post Traumatic Growth
32. Veterans Career Fair

The 5-day 2014 10th Anniversary Accountability Courts Conference: Different Paths, One Goal Conference, held in Atlanta, GA, was attended by 1,000+ people. While DBHDD had partnered in a more general way to co-sponsor the event in 2012, the more specific and detailed work in 2014 helped to ensure that the cross-training needs of GA's behavioral health providers, law enforcement, court personnel, government agency, non-profit, faith-based, and other Veteran-serving social service agencies can be addressed in multiple arenas each year. The Veterans Track included 23 workshop sessions. A sample of sessions is listed below:

- Arts, Expressive Arts Therapies, Technology, Dreamwork, and Equine Therapy: Healing Interventions
- Veterans Treatment Court: Mentor Bootcamp (first in the state)
- The Role of Veterans Justice Outreach (VJO) Workers in Veterans Treatment Courts
- Focusing on the Importance of Veterans Treatment Courts (Keynote address by Judge Robert T. Russell, Buffalo Veterans Treatment Court)
- Law Enforcement Tools for Supporting Veterans in Transition
- Addressing Trauma, Addictive Disease and Other Co-Occurring Disorders with Veterans & Others
- Have You Ever Served in the Military? An American Academy of Nursing Awareness Campaign Initiative
- Are We There Yet? Skills and Strategies for Supporting Military Children Through Transition
- Special Considerations for Working with Homeless Veterans
- Employment Initiatives for Returning Veterans
- Veterans Courts in Georgia: Our Veterans Deserve This Treatment
- Understanding and Accessing Veteran Benefits
- Coalition Building for Effective Service to Veterans and Military Families
- Transitioning from Combat to the Civilian World
- Cognitive Behavioral Therapy, Virtual Reality Applications in the Treatment of PTSD for the Wounded
- Public Safety De-Escalation Strategies for Military Veterans in Crisis

DBHDD is member of Georgia's Returning Veterans Task Force (RVTF), a legislatively mandated intra-state task force that investigates how Georgia's state government agencies can coordinate services, to include behavioral health services for veterans and their family members, to better assist service members transitioning from active duty back into society. Including the Georgia Department of Veteran Services (GDVS), which coordinates the group, the RVTF is comprised of 12 member agencies and organizations, including:

- DBHDD
- Department of Community Health
- Georgia Department of Defense
- Department of Human Services
- Department of Labor
- Secretary of State
- Georgia Veterans Education Career Transition Resource Center (VECTR)
- Council of Accountability Court Judges
- Technical College System of Georgia
- University System of Georgia
- Workforce Division of the Georgia Department of Economic Development

DBHDD brings behavioral health expertise and resources to the table to assist with identification and coordination of treatment, support services, and other state resources for veterans and their family members with mental health challenges, substance use disorders, or intellectual and developmental disabilities.

Limited English Proficiency and Sensory Impairment (LEPSI)

Georgia is a culturally diverse state with many spoken languages. The Department of Administrative Services (DAOS), through a competitive procurement process, selects qualified interpreting service vendors to accommodate all interpreting service needs for state agencies. DBHDD operates a policy on the provision of meaningful language access to all programs and activities conducted or supported by the department. In FY11, a LEPSI Contract Expectation was added that requires all contracted service agencies to offer meaningful communication assistance at no cost to the consumer. Due to the lack of bi-lingual and sign fluent mental health practitioners, providers rely upon interpreters to facilitate communication between practitioners and consumers with limited English proficiency and sensory impairment. DBHDD maintains agreements with qualified Language Service Vendors to provide interpreting services to state and contracted services at pre-determined rates.

DBHDD is committed to providing reasonable accommodations to facilitate effective communication when accessing services DBHDD itself provides. For individuals with limited English proficiency, DBHDD provides language assistance services, including translated

documents and oral interpretation, free of charge, when such services are necessary to provide meaningful access to services DBHDD itself provides. For individuals with sensory impairment, DBHDD provides appropriate auxiliary aids and services, including qualified interpreters and information in alternative formats, free of charge, when such aids and services are necessary to provide meaningful access to services DBHDD itself provides.

The responsibility for coordinating accommodations for DBHDD field offices is assigned to the Behavioral Health Field Office Access Coordinator (BH-FOAC) for each region, as identified by the Director of Field Operations, Division of Behavioral Health, and the Developmental Disability Field Office Access Coordinator (DD-FOAC) for each region, as identified by the Director of Field Operations, Division of Developmental Disabilities. The BH-FOAC and DD-FOAC serve as a resource for inquiries about, and oversight of, communication accommodations. Policy 15 -103 details the responsibilities of the BH-FOAC and the DD-FOAC in relation to facilitating effective communication for individuals receiving services that DBHDD itself provides in the regions.

Additionally, as mentioned above, the DBHDD and DCH implemented a 2017 expansion of telemedicine policy to allow individuals who speak a language other than English to access any practitioners who speak their language via telemedicine (including ASL).

Deaf, Deaf-Blind, and Hard of Hearing Populations

It is Georgia's vision that all individuals, including individuals who are deaf, deaf-blind, or hard of hearing and utilize ASL as a preferred language, have easy access to linguistically accessible and culturally competent high-quality care that leads to a life of recovery and independence.

Identification of Individuals with Hearing Loss. Paramount to providing high-quality services is the thorough understanding of the population served. Toward that end, DBHDD added nine mandatory demographic questions for providers to better identify individuals with hearing loss. These questions tentatively establish the hearing/vision status and language modes/preference of all individuals seeking services. A DBHDD policy titled "Provider Procedures for Referral and Reporting of Individuals who are Deaf, Deaf-Blind, and Hard of Hearing" requires DBHDD providers to notify the ODS of an individual with hearing loss within 48 business hours of referral or contact.

Identification of Communication Preferences and Needs. Once an individual with hearing loss is identified, ODS Communication Assessors conduct a Communication Assessment to identify the individual's communication access needs and preferences. Accommodation recommendations are documented in the ODS Communication Assessment Report. If an individual chooses not to receive recommended ODS accommodations, they may waive such services. A DBHDD policy titled "Communication Assessment Procedures for Individuals with Hearing Loss" provides the

objectives of the communication assessment and specifies that providers are expected to use this document in understanding the required communication needs of the individual while they are accessing DBHDD services.

Development of Statewide Community-Based Accessible Services. In August 2015, ODS signed a contract with Avita Community Partners to hire an ASL fluent therapist and an ASL fluent Case Manager to provide culturally and linguistically affirmative behavioral health services to individuals who are deaf, deaf-blind, and hard of hearing in Avita's Community Service Area and designated neighboring areas. This contract has been expanded to allow Avita to partner with all CSBs to provide ASL fluent services to individuals who are deaf, deaf-blind, and hard of hearing in every county in the state, either on-site or via telemedicine. A DBHDD policy titled "Accessibility of Community Behavioral Health Services for Individuals Who are Deaf and Hard of Hearing" outlines the expectations that providers endeavor to offer direct communication via an ASL fluent therapist to individuals who prefer that approach. This policy also has instructions on how providers can book and schedule interpreters, how the providers can work with sign language interpreters as well as basic expectations for providers should they desire to hire staff interpreters, or ASL fluent clinicians or case managers.

Workforce Development of Qualified Mental Health Interpreters (QI) and Georgia Behavioral Health Interpreters (GaBHIs). With few ASL-fluent behavioral health professionals practicing in Georgia, service providers must rely upon QIs and GaBHIs to provide appropriate access to services. In addition to the nationally recognized credential of a QI, DBHDD has established a state-centric behavioral health interpreter designation, GaBHI. DBHDD offers ten scholarships annually for local interpreters to attend the Mental Health Interpreter Training (MHIT) in Montgomery, Alabama as a first step in becoming a GaBHI. After attending MHIT, these interpreters are required to obtain a total of 40 hours in practicum with supervision from a qualified supervisor. To date, more than 35 interpreters have attended MHIT or an equivalent training to begin the process of earning a GaBHI designation. DBHDD has hired 13 of these and three are GaBHIs. (As well, the QI and the GaBHI credential are held by the interpreter coordinator for DBHDD). QI and GaBHI interpretation services are available to DBHDD Mobile Crisis Services Providers 24/7, either in-person or via HIPAA-compliant browser-based video relay.

Deaf Services Provider Training Series. In addition to the above efforts, ODS is committed to making basic training available to all providers to increase communication skills and cultural competency among non-signing service providers to promote a supportive trauma-informed care environment and reduce possible communication barriers. This training includes the utilization of accessible informational materials (videos, visual aids, auxiliary aids, etc.) to bridge communication gaps in the temporary absence of Qualified Mental Health Interpreters (QI), GaBHIs or ASL-fluent professionals. ODS has developed a webinar for Crisis Providers directly

targeting the Deaf/Hearing Loss population who may or may not communicate in sign language. Additionally, ODS has provided a webinar that has been modified to meet the needs of community behavioral health providers.

Promotion of Public Information Awareness and Community Outreach. Essential to utilization of behavioral health services, is the public's awareness of the availability of those services. Toward that end, ODS has promoted education and awareness of DBHDD's increased provision of accessible services. These efforts going forward will include development of ASL translations of available services and written materials, hosting Deaf Community Conversations for the community, and attendance/sponsorship of numerous state conferences and local Deaf community events.

Criterion V: Management Systems

Fiscal Resources

The FY20 total annual budget for adult mental health in Georgia is $457,387,413 million. Of the total adult mental health budget, about 86% goes to fund community- based services. The remainder funds state hospitals. Of the adult budget 97% comes from state dollars, and 3% of adult community mental health is funded with federal dollars.

As part of the ADA Settlement Agreement, in FY12, DBHDD was appropriated $32,013,761 in the amended budget for the last quarter of the fiscal year; for FY 13 appropriated $52,356,013; in FY14 appropriated $73,913,477; in FY15 appropriated $97,997,387; in FY16 $2,313,015; in FY17 $6,133,276; in FY18 $7,756,876; and in FY19 the Department was appropriated $5,721,600. These funds support the expansion of community-based mental health services. In addition, part of this funding supports community transition needs of consumers being discharged from the state hospitals, particularly some transportation funds, etc., and there is increased staff capacity to meet the obligations of the Settlement Agreement.

The total amount of Mental Health Block Grant funding available for adult mental health services and administration in SFY20 is $15,178,419, and of this amount, $14, 421,645 is provided for Supported Employment, Peer Support Services and Mental Health Treatment Courts. An additional $783,016 is available to support other activities such as provider training, Georgia Mental Health Consumer Network for Peer Mentor development, the Peer Specialist Training and Certification Program, support to the Georgia Behavioral Health Planning and Advisory Council and state administration.

Human Resources

DBHDD has actively sought to improve its workforce to better deliver quality services. Certified Peer Specialists (CPSs) have added tremendous value to the workforce as trained recovery specialists. CPSs are required staff for Assertive Community Treatment teams, Core

Services and Peer Supports and Coordinated Specialty Care teams for the LIGHT-ETP for first episode psychosis. In addition, they are recommended staff for Psychosocial Rehabilitation.

In order to provide a pool of qualified applicants for these positions, DBHDD, through a contract with the Georgia Mental Health Consumer Network (GMHCN) developed a training and certification program for CPSs. While several states have utilized Peer Specialists in service provision, this was the first certification program to be developed anywhere in the country. Block grant funds support staff positions at GMHCN to implement and monitor the certification program. Additionally, block grant funds are utilized to conduct the training and continuing education activities.

The driving force of DBHDD's system transformation is the continued development of the certified peer workforce. Agents of recovery and transformation, Georgia's CPSs inspire and support adult mental health consumers to recognize their dreams, preferences and strengths, and to learn skills to take responsibility for their recovery and creation of a meaningful life. As in any successful marketplace, the needs and desires of consumers transform the characteristics and delivery of services. CPSs advocate for and support development of the consumer voice. And, as employees of community behavioral health service providers, state-run psychiatric hospitals, regional and state DBHDD offices, as well as advocacy and other mental health system stakeholder organizations, CPSs are actively involved in shaping, defining and delivering consumer-directed, recovery-oriented services, that transform lives and systems.

The Georgia CPS Project, operating since 2001, is administered via the contract with GMHCN. The Director of the DBHDD Office of Recovery Transformation partners closely with the Executive Director of GMHCN to provide consultation and technical assistance on the development and utilization of Georgia's adult mental health peer workforce.

Georgia's utilization of peer specialists is expanding. With funding from a SAMHSA Transformation Transfer Initiative grant, Georgia created a standardized curriculum to certify CPSs to provide health and wellness supports. Certified Peer Supported Whole Health and Wellness Coaches work in partnership with a registered nurse to support individuals with behavioral health conditions in setting and achieving health goals related to overall mind-body wellness. A pilot program for forensic peer specialists was started in FY15 to support individuals with behavioral health conditions who are in prison to successfully transfer to the community.

The Certified Addiction and Recovery Empowerment Specialist (CARES) program is administered via a contractual partnership with the Georgia Council on Substance Abuse (GCSA). GCSA conducts the CARES Academy, which teaches individuals how to use their lived experience with recovery from substance use to support their peers in recovery. Individuals

who complete the 40-hour experiential classroom work and pass the certification test become Certified Addiction and Recovery Empowerment Specialists (CARES). CARES (aka CPS-AD) and provide peer support services to people with substance use disorders in Georgia's continuum of care.

In FY15 DBHDD implemented The Recovery-Focused Change Initiative pilot training and technical assistance in best practices associated with facilitating sustainable recovery-focused change in provider agencies. Each provider established a Recovery Change Team consisting of various agency staff, consumers, board members, family members and other stakeholders and participated in a 2-day workshop that included team building activities, stories about and examples of ways other agencies successfully transitioned to a recovery-focused service agency; and an opportunity to discuss and choose 4-6 projects the change team would like to work on at their agency. Technical assistance was provided to each change team after the 2-day training, to support them in completing their projects and continuing on their path to recovery transformation. The Recovery-Focused Change Initiative will continue in FY18, as a significant component of DBHDD's strategic plan to be transform to a Recovery-Oriented System of Care.

DBHDD recognizes the critical importance of staff development and training in strengthening adult mental health services in Georgia. The Office of Adult Mental Health in conjunction with the training department for the agency coordinates training and facilitates the many training and development activities offered through DBHDD. Some training initiatives are generated in response to gaps and challenges identified by various reviews and audits and others are developed as a result of quality improvement activities. All trainings are intended to improve the clinical skills of providers with whom the Department contracts for service delivery.
The Office of Adult Mental Health in collaboration with the DBHDD University, facilitates training and development activities on topics identified by the Office of Adult Mental Health During FY 2018 and FY 2019, there were several broad areas that received attention for adult mental health services training:

BECK INITIATIVE

- DBHDD is contracting with the University of Pennsylvania's Aaron T. Beck Psychopathology Research Center to provide recovery-oriented cognitive therapy (CT-R) training workshops and group consultation for select state hospital and community provider staff. The purpose of the training is to provide tools to clinicians to engage individuals with persistent schizophrenia in one-on-one psychotherapy in the community. The intended result is to help individuals with severe mental illness sustain themselves in the community, anticipate and overcome challenges, and further progress toward recovery. Training, consultation and sustainability activities continue for providers statewide.

- **Mental Health First Aid (MHFA)** training April 25, May 1, 23, June 9, 16, 2017 was offered to contracted paraprofessional staff and Certified Peer Specialists (CARES included) of DBHDD contractors who provide Adult Mental Health Supported Employment, Community Residential Rehabilitation, PATH, Forensic Peer Mentor services and other adult community mental health services. Mental Health First Aid training is a groundbreaking public education program that;
    - introduces participants to the risk factors & warning signs of mental health and co-occurring substance abuse disorders;
    - builds understanding of the impact of behavioral health disorders & common treatments
    - teaches participants a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer and self-help resources.
    - promotes mental health literacy, combats the stigma of mental illness and enables early behavioral health intervention.

- Community Residential Rehabilitation services training February 20, 21, 27, April 26, 27 and May 1, 2017. This three-part series of trainings was geared toward preparing providers to deliver Medicaid reimbursable residential rehabilitation services, and operationalizing the draft new CRR service definitions. The first training session of this series was offered in December, the second session was offered in February. This training enhanced adult mental health residential providers' knowledge, understanding and ability to deliver and be reimbursed for Medicaid billable residential rehabilitation services that promote community integration and housing stability.

- Trauma Informed Care Training April 20, 21 and March 27 and 28, 2017. This training focused on promoting an understanding of and ability to effectively support various types of trauma that may present in the population served by our AMH community services. This was a two-day training, for providers of ACT, CST, ICM, CM, and CSU services.

- ANSA/CANS training 3/26/19, 3/27/19. This training was for all contracted providers who facilitate functional assessments; all clinical supervisors, and clinicians/practitioners such that any DBHDD contracted provider of child/adolescent, adult mental health and addictive disease services who has responsibility for administering and/or supervising staff who administer the ANSA and or CANS will be trained to do so.

- Housing First training January 9, 10, March 14, 15, 16, May 10, 12, June 12, 13, 14 2017. This three-part training series was geared toward supporting our network of providers incorporation of recovery-oriented practices that promote increased choice and transition into independent supported housing for Individuals accessing our services. This training

was provided for all DBHDD contracted Providers of the following Community Based Adult Mental Health Services; Assertive Community Treatment (ACT), Community Support Team (CST), Intensive Case Management (ICM), Case Management (CM), and Projects for Assistance in Transition from Homelessness (PATH).

- Integrated Dual Diagnosis Treatment training, June 1, 2, 7 and February 13, 14, 15, 2017. Integrated Dual Disorder Treatment (IDDT) Advanced Training. This was an advanced level training, participants developed an enhanced understanding of principals and practice standards for IDDT, and increased their knowledge and ability to utilize effective strategies and techniques to support the complex addictive disease and mental health needs of the population of individuals accessing ACT and CST services.

- Community Housing Resources training June 26 and 27, 2017. This training focused on promoting awareness of resources that support access to safe and affordable housing options for the individuals served in adult mental health. The partnership with the Department of Community Affairs (DCA) was highlighted, which has allowed for an increase in access to the array of rental assistance programs for the target population such as the DCA housing choice voucher and HUD section 811 program.

- Transition Planning March 2, 3, 7, 8, 13, 2017. Participants received information about the overall transition planning policy. In addition, they were provided an understanding of the components of the transition planning process and the procedures that comprise it, including the specific steps of the procedures and documentation that captures the outcomes of those procedures.

- Maternal Mental Health training February 2, 21, 28, 2017. This training focused on the behavioral health needs of pregnant and or postpartum women. Mood disorders, particularly depression, are one of the most common complications during and after pregnancy, another related complication- postpartum psychosis is also a serious illness that can be quite severe. This training content will include signs and symptoms of Perinatal Mood and Anxiety Disorders, screening and treatment options and best practices in supporting the behavioral health needs of this population.

- Coordinated Entry and HUD Program Eligibility December 12, 2018. Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

- The Right Response training provides specific behavior management skills and techniques for providers who support individuals in residential type settings. March 11, 12, 13, 2019

- Housing Quality Standards Wednesday, February 20, 2019. The Housing Quality Standards (HQS) set acceptable conditions for interior living space, building exterior, heating and plumbing systems, and general health and safety in a dwelling.

- Fair Housing Wednesday, April 24, 2019. The Fair Housing Act is a federal act in the United States intended to protect the buyer or renter of a dwelling from seller or landlord discrimination.

- Motivational Interviewing- November 2018

- ACT and CST TL Retreats 6/22/18, 7/12/19

Crisis System Optimization

Consultants from RI International provided training in two phases. Phase one offered a one-day training that was repeated in Northern, Central and Southern Georgia. The focus of phase one was on orienting current providers to new model of crisis services that focused on the needs of the community as a whole. Topics addressed were:

- Peer engagement as an integral component of crisis service delivery
- Managing and supporting a peer workforce in a crisis environment
- No force first: Active recovery-oriented treatment in crisis settings
- Welcoming spaces: lobby and intake area
- Keys to improving throughput: observation area structure and function
- Tracking cost avoidance: Acute inpatient diversion
- Strengthening first responder relationships and emergency department diversion
- Changing the law enforcement relationship: No refusal of crisis referrals
- Crisis system structure to meet the needs of the community

Phase II training followed a round of site visits by consultants and revolve around three recurring themes informed by the visits. These themes were; enhancing patient engagement, the role of peers in crisis work, and creating lasting culture change. To this end, the RI International Consultants conducted 3 specific trainings:

- A train the trainer presentation on the AIDET model of patient engagement. This training included fidelity measures and tools to incorporate the model into all aspects of supervision.
- A deeper dive on utilizing peer supports to engage patients and enhance throughput
- An in-depth presentation on sustainable culture change utilizing Gallup research and practical applications around "the 12 questions".

COMMUNITY BEHAVIORAL HEALTH SYMPOSIUMS October 2018 and upcoming in October 2019

- Adult Mental Health Training:
  2-Day training and technical assistance for community behavioral health providers of adult services. Providers to learn about best practices, outcome achievement, strategies to assist in treatment interventions, hear from peers, and understand expected treatment outcomes for targeted populations.

SUPPORTED EMPLOYMENT

- A series of 12 session webinars provided to SE staff on the Individual Placement and Supports (IPS) model of SE: September- December 2016.

THE BASICS

- In order to ensure that paraprofessionals who provide behavioral health services have met basic training expectations, DBHDD continues to utilize the online learning vendor, Relias (formerly Essential Learning) to provide standardized training preparing paraprofessionals to work in the field of mental health; all paraprofessionals are required to complete required courses shortly after hire. Required topics include:
  - Corporate Compliance
  - Cultural Competence/Diversity
  - Documentation
  - Understanding Mental Illness – Addictive Disorders
  - Pharmacology and Medication Self Administration
  - Professional Relationships
  - Recovery Principles
  - Safety/Crisis De-escalation
  - Service Coordination
  - Suicide Risk Assessment (Must choose at least 2 hours of online training)
- Key trainings on basic topics such as documentation and incident investigation are routinely offered for DBHDD providers.
- DBHDD University offers a Learning Management System (LMS) that provides online educational opportunities for both DBHDD staff and contracted community service providers. The LMS provides for course registration, record of course completions, assessment grades, transcripts, and printable course certificates.
- The Administrative Service Organization provides basic orientation to newly enrolled providers including basic utilization management (prior authorization, continued stay reviews, discharge processes), quality management reviews, and compliance.

Community behavioral health services in Georgia are provided through a number of contracted public and private provider agencies. These are not state agencies and therefore we do not have

specific knowledge about the numbers of staff of differing professional disciplines that are employed by each agency. Staffing requirements for services within the Georgia Behavioral Health system are established in both the DBHDD *Provider Manual for Community Behavioral Health Services* and the Medicaid Services Manual. Practitioners are divided into Professional and Paraprofessional categories, and licensed behavioral health professionals practice under the scope of relevant practice laws. Paraprofessionals are those practitioners who are not licensed or certified and must complete a standardized curriculum approved by the Department of Community Health and DBHDD. Each service definition contains specific staffing patterns that include the required level of supervision by a licensed practitioner, as well as staff to consumer ratios that meet standards of care. Urban areas of the state generally have more access to all categories of professional staff. The Health Resources Services Administration (HRSA) has designated many parts of the state as "Mental Health Professional Shortage Areas," highlighting the fact that recruiting and retaining qualified staff presents a continuous challenge to rural providers. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are being made to secure qualified staff for services provision. Georgia strategically continues to grow the guild of Certified Peer Specialists to assist in promoting access and engagement while the workforce shortage persists.

Disaster Preparedness

DBHDD has a Disaster Mental Health Coordinator's (DMHC) position which is fully funded by the Georgia Department of Public Health. DBHDD's DMHC works with the Georgia Emergency Management Agency and other emergency preparedness agencies to ensure that the behavioral health needs of Georgia residents are included in state-level plans by participating in numerous workgroups and task forces. The DBHDD Regional Hospitals and provider agencies are members of Regional Emergency Preparedness Healthcare Coalitions throughout the state and they participate in exercises with local healthcare and emergency preparedness partners. ACT, CST, ICM, CM, and SE providers receive training in continuity of operations and personal disaster planning as well as training on how to work with individuals to develop a personal disaster plan. Georgia's disaster mental health website at www.georgiadisaster.info contains information and resources on disaster mental health planning. DBHDD has a continuity of operations plan policy for its state office and policy that requires continuity of operations for all contracted providers. Disaster mental health training and exercises takes place throughout the state several times a year.

Emergency Services Worker Training

All services in the Georgia DBHDD system are provided under contract or agreement with private or public providers of behavioral health services. Local providers work with emergency personnel such as Sheriff's Departments, Hospital Emergency Rooms and county jails on issues related to consumers with behavioral health needs. The local providers educate these responders on the needs of consumers as well as on the services available through their agencies. In

particular, in areas that are more rural, provider staff develops relationships with local hospital emergency rooms and other responders to keep them apprised of the unique needs of persons with mental illness and serious emotional disturbance in emergency situations. In the more metropolitan regions, the providers sometimes contract with outside vendors to do training of emergency personnel.

Behavioral Health Link provides information and marketing materials regarding the Georgia Crisis and Access Line to hospital emergency room personnel and local law enforcement staff. The intent is for all emergency services personnel to be informed of the availability and process for accessing 24/7 crisis response for any individuals in a crisis related to mental illness or addictive diseases.

In September of 2016, Governor Nathan Deal announced a law enforcement reform package that includes a multi-phase overhaul of officer training and certification courses. The reform package includes enhanced resources for Georgia Crisis Intervention Team (CIT) and a provision that will involve the transfer of CIT to the Georgia Public Safety Training Center (GPSTC), thereby streamlining training requirements and increasing access to more than 57,000 state and local officers. DBHDD now blends funds with GPSTC, to provide CIT training to Georgia's law enforcement officers using a curriculum that blends best evidence based practices from the new Bureau of Justice Assistance (BJA) CIT Model, the Memphis, Tennessee CIT model, and data gained from CIT practice in the field since 2006 In an effort to reduce the stigma associated with mental illness, the Georgia CIT Program's vision is a Georgia where citizens with serious mental illness receive medical treatment in lieu of incarceration. Georgia adopted a top-down approach to training law enforcement by forming a collaborative with executives from key departments of state government, mental health providers and advocacy organizations.

From FY06 through FY17, the CIT (Crisis Intervention Team) Program collaboration between NAMI Georgia and DBHDD trained police officers across the state to divert consumers from incarceration and link them to treatment services. In FY17, 55 CIT trainings were conducted reaching more than 1,000 law enforcement officers. In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, NAMI facilitated a new DBHDD-funded Introduction to Behavioral Health Crisis curriculum--seven (7) 16-hour courses for Law Enforcement Officers waiting to attend the 40-hour CIT class, and eight (8) 8-hour courses for First Responders and 911 Operators— The goal and objective of the new **training** is to provide an in-service introductory course on behavioral health crisis for law enforcement officers as a precursor to the Georgia CIT Program. Components of the new class include:

1. An introduction to signs and symptoms of the behavioral health disorders law enforcement officers are most likely to see during their day-to-day encounters with citizens experiencing behavioral health crisis, disorders such as Depression, Bipolar Disorder, Post Traumatic Stress, Schizophrenia and Autism.
2. Statistics on the prevalence of mental illness, including information on incarceration rates, suicide, homelessness, recovery success rates, and the impact of stigma.
3. A basic overview on Legal Issues highlighting some of the Official Codes of Georgia relative to 1013, Probate Orders (OTA), transports, immunity, HIPPA, case law citing deliberate indifference, and Georgia Accountability Courts.
4. Community resources including information on the Department of Behavioral Health and Developmental Disabilities (DBHDD), Behavioral Health Link (BHL), Community Service Boards (CSBs), Advocacy and Recovery organizations such as National Alliance on Mental Illness (NAMI), Georgia Mental Health Consumer Network (GMHCN), Georgia Parent Support Network (GPSN), and the Georgia Council on Substance Abuse
5. Consumer Perspective featuring an "In Our Own Voice" presentation by a person living in recovery with mental illness. The presenter shares dark days of mental illness, acceptance, treatment, success hopes and dreams.
6. The last module will be an introduction to CIT, citing the history of CIT, benefits of CIT training, successful CIT outcomes, and skills taught during the course.

The state's Crisis Intervention Team Training Manual states that one of the main collaborative objectives between the GBI and NAMI is to "Ensure that people with mental illnesses and other brain disorders always receive treatment, in lieu of incarceration in most cases."

The Georgia Bureau of Investigation (GBI) has incorporated a module on trauma into its monthly training for new Crisis Intervention Team (CIT) State Patrol officers across the state. The training includes interviews with actual consumers who have received services for PTSD, education on the signs and symptoms of trauma and other mental illnesses, as well as de-escalation techniques for use in working with persons in crisis related to trauma. A goal of the CIT training program is that officers understand that involvement in many infractions of the law may be a result of a person's trauma history or failure to receive proper trauma-informed treatment, rather than a result of intentional wrongdoing.

The FY18 transition of CIT to GPSTC will allow for expansion of CIT training to at least double the number of officers reached in previous years, and will allow for development of "CIT University". New online training modules will be developed to provide advanced add-on training for CIT certified officers. Modules may include trauma, similar to the current GBI module, Alzheimers and Dementia, veterans, youth in crisis, autism, and other topics designed to increase officers' knowledge and improve responses in the field.

DBHDD's Assistant Director of Adult Mental Health Services is the Program Manager for the GPSTC contract and one of AMH's Behavioral Health Treatment Court Liaisons is a member of the GPSTC Crisis Intervention Team Training Advisory Board.

CHILD AND ADOLESCENT MENTAL HEALTH

Criterion I: Comprehensive Community-Based Mental Health Service System
DBHDD provides a comprehensive community-based system of mental health care for children and adolescents with serious emotional disturbances (SED) and their families who need public services. The mission of the Office of Children, Young Adults, and Families (OCYF), is to provide for a comprehensive, quality public mental health system for children, young adults and families. OCYF offers children, young adults and their families, a range of treatment and support services to address emotional and behavioral disorders. Early treatment is critical to helping youth cope with isolation, stigma, and other challenges involved in living with SED. Youth with SED have diagnosable mental, behavioral, or emotional concerns, which are persistent and interfere with their family life, community activities and school. They need a range of treatment and support services that allow them to live at home whenever possible, continue school and take part in community life and childhood activities. Youth with substance use challenges have diagnosable substance use disorders as a primary diagnosis and many have both SED and substance abuse co-occurring disorders that need specialized treatment interventions and approaches.

DBHDD has made efforts to expand community-based mental health services for youth and their families. The first funding for community-based child and adolescent mental health service expansions was appropriated by the state legislature in FY89 and totaled $450,000. The total amount of state and MHBG funding available for FY19 in Child and Adolescent Community Mental Health is over $77 million. An array of community based mental health services is provided in each service area of the state. While not all services are available in every one of Georgia's 159 counties, each county is included in one of the state's six regions. The full array of services is provided in the lead counties of the services areas, at a minimum, with some services available in satellite offices or through mobile service delivery.

Through a standardized provider application process, organizations are encouraged to apply to become authorized providers to increase consumer choice. All Behavioral Health providers under contract with DBHDD must adhere to the Department of Behavioral Health and Developmental Disabilities Provider Manual Community Behavioral Health, which includes requirements and utilization guidelines for all providers. The requirements identified in the manual assure that an organized system of care is available to citizens of Georgia wherever they live in the state and according to individual need. Services are required to be provided in a culturally appropriate and competent manner by providers with a workforce trained to recognize

and address diverse needs. All Providers must be accredited at the time of application and continuously recredentialed by one of the following organizations: The Joint Commission (TJC), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Council on Quality and Leadership (CQL).

As indicated in the Adult Mental Health section of this application, DBHDD has implemented a Tiered Provider Network. This same Tiered approach applies to child and adolescent mental health and substance abuse services. Tier 1, Comprehensive Community Providers (CCPs), must provide services to children, adolescents and emerging adults. Community Service Boards are Tier 1 providers and the established safety net and public providers of behavioral health and developmental disability services in Georgia. They provide outpatient behavioral health services and specialty services. In addition to the 24 Community Service Boards, a network of private providers offers an array of community services for youth with SED. There are 108 Tier 2, Medicaid only providers and 40 providers of specialty services (Tier 3) such as Intensive Family Intervention Services and Resiliency Clubhouse Services. Each provider, whether public or private, has a Letter of Agreement or contract to provide services.

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Provider contracts and agreements identify who is to be served with DBHDD funding. Because of growing pressure for services using the public dollar, it became imperative to identify those eligible to receive services, and the level of services to be offered. A "Core Customer" definition was developed which has as its foundation the elements of the federal definition for SED. This eligibility criteria better defines the population of youth to be served utilizing state and federal resources, within the public mental health system. The definition is addressed in the Unmet Need section of this MHBG plan.

The target population for DBHDD to serve changed with the implementation of managed care for those eligible for Medicaid. DBHDD is not responsible for providing behavioral health services to all youth with behavioral health conditions. The public behavioral health benefits in Georgia are covered through a variety of mechanisms.

- CHIP-covered youth are served through four (4) managed care organizations (CMOs) which are procured and managed by the state's Medicaid authority, the Department of Community Health (DCH);
- Youth in the custody of the state through the Departments of Human Services and/or Juvenile Justice are served through a single managed care organization which is procured and managed by the state's Medicaid authority, the DCH (this contract also allows adoptive assistance families to option this coverage);
- Youth who qualify for Medicaid as "disabled" are served by a fee-for-service benefit plan which is collaboratively implemented by the DCH and the DBHDD;
- Youth who are uninsured are served by a fee-for-service benefit plan which is implemented by DBHDD; and additionally

- Some youth may have limited behavioral health coverage by private insurance plans and may qualify for some ancillary support through state and federal funds.

The benefit plans required of the CMOs are designed in collaboration between the DCH and DBHDD (which are approved under the Medicaid Rehabilitation Option), but the DCH allows the CMO vendors to uniquely carry out aspects of the benefit, including medical necessity criteria, authorization parameters, and determination of provider qualifications. Many of the DBHDD providers are enrolled with the CMOs.

The majority of children's services administered by the DBHDD are paid utilizing a Fee for Service method. DBHDD moved to a Fee for Service Model for state funded services whereby the majority of funding available for child and adolescent behavioral health services is no longer allocated through a contracting process. All of the Essential Services and Intensive Family Intervention (IFI) services are provided through this method. Because DBHDD has a finite amount of state funding available for services, the agency must monitor utilization and expenditures to maintain budget stability. To that end, DBHDD implemented a review process to monitor providers' use of state funds to ensure that no other third-party resources are available to cover the cost of service. Some specialty services, such as crisis stabilization units, mobile crisis services, Care Management, and Resiliency Clubhouses are provided through contracts.

Below are brief descriptions of services provided to children and adolescents from the DBHDD Provider Manual:

C&A Non-Intensive Outpatient Services

- **Behavioral Health Assessment**

  Face-to-Face comprehensive assessment with the individual that includes the individual's perspective (and that of family and significant others as well as collateral agencies/treatment providers).

- **Diagnostic Assessment**

  Psychiatric diagnostic interview examination completed in a face-to-face format (which may include the use of telemedicine) and may include family and other sources.

- **Psychological Testing**

  Face-to-face assessment of emotional functioning, personality, cognitive functioning or intellectual ability using objective and standardized tools that have uniform procedures for administration and scoring, and utilizes normative data upon which interpretation of results is based.

- **Crisis intervention**

Designed to prevent out of home placements or hospitalization. Time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.

- **Medication Administration**

An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with youth's resiliency plan, must also be included.

- **Nursing Assessment and Health Services**

Requires face-to-face with youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or physical problems and general wellness of the youth.

- **Psychiatric Treatment**

The provision of specialized medical and/or psychiatric services, including medication management and psychiatric psychotherapy, assessment, and monitoring, performed by a Board-Certified medical doctor licensed in the State of Georgia.

- **Community Support**

Rehabilitative, environmental support and resource coordination considered essential to assist a child/youth and family in gaining access to necessary services and in creating environment that promote resiliency and support the emotional and functional growth and development of the child/youth.

- **Family Counseling**

A therapeutic intervention or counseling service (successful with family populations) directed towards specific goals defined by youth and parent(s)/responsible caregiver(s) conducted by licensed staff, and specified in the Individualized Resiliency Plan.

- **Family Training**

Systematic interactions between identified individual, staff, and family directed towards restoration, development, enhancement, or maintenance of functioning of individual/family unit. This may include support of family, as well as training and specific interventions/activities to enhance family roles, relationship, communication and functioning

promoting resiliency of family unit. This is directed toward the achievement of specific goals defined by the youth, parent(s), or responsible caregiver(s).

- **Group Counseling**

Group based therapeutic intervention or counseling service successful with populations, diagnoses, and needs. Directed toward the achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s).

- **Group Training**

Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of such things as problem solving skills, illness and medication self-management knowledge and skills, and healthy coping mechanisms.

- **Individual Counseling**

A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses, and service needs, provided by a qualified clinician. Techniques employed involve principles, methods, and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal, interpersonal concerns.

- **Service Plan Development**

Development of the Individualized Recovery/Resiliency Plan based on the results of the Diagnostic and Behavioral health assessments. Plan is required within the first 30 days of service.

- **Community Transition Planning**

Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility. Additional Transition Planning activities include: educating the individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan

Specialty Services

- **Intensive Family Intervention**

Services intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out-of-home therapeutic venues for the identified youth. Services are delivered utilizing a team approach and are provided primarily to the youth in their living arrangement and within the family

system. This service includes crisis intervention, intensive supporting resources management, resource coordination, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services.

- **Child and Adolescent Structured Residential Supports**

Formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2, are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders.

- **Crisis Stabilization Units**

This is a medically monitored residential treatment alternative to, or diversion from, inpatient hospitalization, offering short-term psychiatric stabilization and detoxification services.

- **Community Based Inpatient Psychiatric and Substance Detoxification Services**

A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder.

- **Mobile Crisis**

This service provides time-limited crisis intervention in the community to reduce escalation of a crisis situation, relieve the immediate distress of individuals experiencing a crisis situation, reduce the risk of individuals doing harm to themselves or others, and to promote timely access to appropriate services for those who require ongoing mental health and co-occurring mental health and substance abuse services. This service is available 24 hours per day, seven days per week.

- **Parent Peer Support Service- Group**

This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent (CPS-P) and uses a group format.

- **Parent Peer Support Service- Individual**

This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent (CPS-P) and uses an individual format.

- **Youth Peer Support- Individual**

This is a strength-based rehabilitative service provided to youth who are living with a mental health, substance use, and/or co-occurring health condition. This one-to-one service, rendered by a Certified Peer Support-Youth (CPS-Y), models recovery by using lived experience as a tool.

- **Psychiatric Residential Treatment Program (PRTF)**

Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment to children, adolescents, and emerging adults from ages six through twenty-one who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been tried and found unsuccessful, or are not medically indicated. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the youth/emerging adult to the community.

- **Intensive Customized Care Coordination**

Intensive customized Care Coordination is a provider-based High-Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought.

- **Clubhouse Services**

Resiliency Support Clubhouse Services for children and youth (ages 6-21) with behavioral health needs has been modeled after its counterpart within addictive diseases. These Resiliency Support Mental Health Clubhouses are designed to provide a comprehensive and unique set of services for children and families coping with the isolation, stigma, and other challenges of mental health disorders.

Services can be provided in schools, child welfare offices, public health offices, juvenile courts, homeless and emergency shelters, youth and family homes, and other community settings defined by the youth and family. Two of the services above that represent treatment approaches that move away from traditional clinic-based services for youth with SED are Intensive Family Intervention (IFI) and Community Support. Youth returning from hospital and residential settings often require higher intensity of services such as IFI. Community Support, which is less intensive than IFI, provides for skill building as well as the essential case management functions of service planning, linking and monitoring to ensure adequacy and continuity of care. These

services are provided to each youth through a service authorization process based on level of need.

For youth between the ages of 6-21 who do not need intensive outpatient services, the DBHDD Office of Children, Young Adults & Families leverages state and MHBG funds to support the Mental Health Resiliency Support Clubhouse program (MH Clubhouse) designed to provide a comprehensive and unique set of services for youth and their families coping with the isolation, stigma and other challenges of mental health disorders. Members and their families participate in clinical sessions, social outings, and career building activities, educational support, and other structured activities designed to support their needs and help them to function better at home, in school, in the community, and throughout life. Fifteen (15) MH clubhouses are geographically located throughout the state.

Community-based Crisis Services

DBHDD has worked, successfully, to move from heavy reliance on acute care hospital services to increased community services. To that end, all state-operated long-term and short-term hospital units were closed some years ago. Comprehensive Community Providers (CCPs) are required to provide crisis services for youth receiving services. In addition, youth in need of acute care, crisis stabilization and treatment are being served through the array of Crisis Stabilization Units (CSUs) and mobile crisis services.

The **Child and Adolescent Crisis Stabilization Unit (CSU)** is a short-term crisis stabilization program for youth with mental health and substance abuse needs. The first community-based CSU was opened in August 2005 utilizing savings from the child and adolescent hospital unit closure at Georgia Regional Hospital Savannah. Four additional CSUs were opened between 2006 and 2009 in Columbus, Rome, Augusta and Atlanta but only one of these programs remain due to underutilization of the programs. The Atlanta program remains open and has 27 beds serving youth ages 14-17. Lakeside CSU in the Savannah area is open and has capacity for 16 beds serving youth ages 5-17. To replace the ones closed and to allow for better geographic access, two CSU's opened in FY10 in Macon and in Greenville, which is in the geographic middle area of the state. The Macon CSU has 16 beds serving youth ages 5-14 and the Greenville CSU has 12 beds serving youth ages 5 – 17. Statewide there are 4 CSUs with a total capacity of 71 beds.

In November 2015 the DBHDD Office of Children, Young Adults and Families entered into contract agreements with nine private in- patient hospitals for **short- term acute crisis stabilization State Contract Beds**. These contract beds provide increased coverage across the state in order to supplement the 71 beds managed by the 4 CSU's. These contract beds are used when CSU beds are unavailable. In addition, youth without insurance or with non- CMO Medicaid are not accepted by a CSU are eligible for review for a State Contract Bed. Also, in

July 2017, three additional private in – patient hospitals were added bringing the total State Contract Bed providers to 12.

Mobile crisis response was funded over a period of time bringing coverage to all 159 counties. Behavioral Health Link, LLC, and Benchmark, Inc. are the providers of mobile crisis services. Georgia's Crisis and Access Line, GCAL, provides continuous access to services for persons in crisis or seeking routine or urgent mental health and/or addictive diseases services via a toll-free phone line. In crisis situations, GCAL connects the person to free-standing mobile crisis services, Crisis Stabilization Units, hospital services, or 911, as applicable to the situation. The call center operates 24/7 and has the capacity to screen and assess callers for intensity of service response. GCAL received over 250,000 calls in FY 17, handled over 160,000 distinct episodes of care and dispatched mobile crisis over 15,000 times of which 3921 dispatches were to youth and their families.

In addition to the need for CSUs, DBHDD identified a need for a Community Intensive Residential Treatment program for juveniles under Superior Court jurisdiction and adjudged as incompetent to stand trial or not guilty by reason of insanity. The program was developed at the end of FY09 to provide psychiatric treatment, competency remediation services, or both for these juveniles who would otherwise be admitted to state hospitals. This secure facility is located in the west central part of the state, has a bed capacity of 14, and typically serves 13-18 year olds. Youth remain there until they return to jail, are transferred to another facility, or discharged to the community.

During FY17, DBHDD developed a contractual agreement with one of the local psychiatric residential treatment facilities (PRTFs) to serve youth ages 12-17 in the juvenile justice system who have been deemed incompetent but restorable. This contract assures that there will be up to six beds available whenever the Department decides, by virtue of a forensic evaluation, that the young person is restorable and can benefit from the appropriate level of care offered by the facility. Once the youth has had the complete assessment to determine the appropriate level of care (up to and including the PRTF level of care), he is enrolled in the program; he also receives competency restoration services from DBHDD's forensics team. The youth will complete the course of treatment and will be referred back to the Juvenile Court upon completion of the competency restoration services.

The state added Psychiatric Rehabilitation Treatment Facility (PRTF) services to the state Medicaid plan in FY08. The PRTF is the highest level of care in the specialty services. There are six PRTFs in Georgia. Youth in parental custody who are under the Medicaid Rehabilitation Option (MRO) coverage, or are uninsured and who are not under Care Management Organization (CMO) Medicaid, are the responsibility of the State, and are reviewed for PRTF eligibility by the State's administrative services organization (ASO), Beacon Health Options, a

member of the Georgia Collaborative. PRTFs serve children and youth ages 6-21 who require an intensive treatment program in an out-of-home setting due to behavioral, emotional, and functional challenges which cannot be safely and sufficiently addressed in the home or community. Referrals to the PRTF level of care made be made by the child's Tier One/core services provider, a crisis stabilization unit (CSU), or another PRTF.

To avoid overuse of the PRTFs, in 2006 Georgia applied for and received a five-year $21 million grant from the Center for Medicare and Medicaid Services. For the grant implementation, Georgia developed a 1915 C Waiver Demonstration Program to develop community-based alternatives to PRTF level of care. With the implementation of the Community Based Alternatives to Psychiatric Residential Treatment Facilities Program (CBAY), DBHDD developed a package of therapeutic and non-therapeutic services for participants to enable them to stay in their home communities and divert them from admission to a PRTF. As part of this implementation, Care Management Entities (CMEs) were created to deliver intensive care coordination and family support utilizing a High-Fidelity Wraparound model of care. The Care Management Entity staff received training in the Wraparound Approach by Innovations Institute from the University of Maryland. Currently, there are two CMEs.

CBAY utilized a systems approach that targeted youth served by multiple agencies, striving to coordinate, blend and braid programs and funding to create a comprehensive behavioral system that ensured youth were placed in and remained in intensive residential treatment only when necessary and that a coordinated system of services at the community level was available. Youth and family that qualified for this waiver, as an addition to the state plan mental health services they were already entitled to, had access to additional services: Care Management, Respite, Supportive Employment Services, Youth Peer Support Services, Family Peer Support Services, Customized Goods and Services, Behavioral Assistance, Community Transition, Consultative Services, Waiver Transportation, and Financial Support Services. In addition, DBHDD provided additional funding to serve youth that did not meet the qualifications for the waiver program, but whose needs were intense enough to need care coordination and family support offered through the CBAY program.

The DBHDD continues to administer a program of high-intensity home and community-based supports for youth who meet PRTF criteria. In the absence of Congress approving PRTFs as an institution for which 1915(c)s can be utilized, the state has continued to continue to provide community services and supports to new youth meeting the level of care for PRTF through the federal Money Follows the Person (MFP) and Balancing Incentive Plan (BIP) to sustain the waiver into a program for youth in PRTFs whose families choose community-based services as an alternative to institutional care. BIP funding ended in 2017, and MFP funding will end in 2020. Although BIP has ended, the program continues to be supported by MFP. In order to achieve greater sustainability for youth who do not meet MFP eligibility, effective 10/1/2017,

Intensive Customized Care Coordination, and Parent and Youth Peer Services, CME services, and associated rates, were added to the State Medicaid Plan and will have rates associated with each service, promoting sustaining access to the services most used by CBAY recipients

CBAY was advised by a CBAY Quality Council and included several family members, DBHDD Office staff, child-serving agency representatives, providers and other selected stakeholders. The CBAY Quality Council continues to meet quarterly, convened by DBHDD's Office of Children, Young Adults and Families, with the following charge: advise on performance and outcome measures to be used in evaluating CBAY services and providers; review information and performance/outcomes data presented and evaluate trends, patterns, systemic issues of concern, as well as positive reports and outcomes of services; and make recommendations on process and service improvements to enhance the program.

To further build on developing these best practice approaches, DBHDD and DCH, Division of Medicaid Assistance, partnered with the states of Wyoming and Maryland along with the National Center for Health Care Strategies (CHCS) to apply for the Centers for Medicare and Medicaid Services Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant to "evaluate promising ideas for improving the quality of children's health care". CHCS, Inc. and the state partners were awarded $10,993,171 over a five-year period to focus on children's behavioral health. The benefits of the partnership would inform other states and CMS about effective approaches and challenges to implementation of the CME provider model. In this work, Georgia focused on:

- evaluating and refining the CME model taking into account best practices nationally,
- evaluating and refining the CME financial model and rate structure,
- evaluating national models of excellence for Care Management
- establishing a continuous quality improvement framework for CMEs
- developing a credentialed network of family and youth peer specialists

The project ended in February 2016 and enabled DBHDD to develop the Certified Peer Support (CPS) training and certification process for both parents and youth with lived experience to provide peer support in Georgia. DBHDD continues to train and certify CPS-Ps (parents) and CPS-Ys (youth). In addition, both parent and youth peer services have been added to the state Medicaid plan to allow providers to bill for peer support services delivered by CPS – P/Y. This will greatly increase consumer access to peer support in Georgia for families and youth experiencing issues with Serious Emotional Disorders (SED).

OCYF Special Initiatives

Over the course of the 2015-2016 academic year, DBHDD's Office of Children, Young Adults, and Families provided grant funding to 29 Tier 1 (i.e. community service boards) and Tier 2 Plus providers to support the integration of community mental health professionals in the learning

environment of targeted schools. This **school-based mental health services program**, known as the Georgia Apex Program, was developed in order to enhance access to the appropriate level of care; to provide early detection of child and adolescent behavioral health needs; and to develop and sustain coordination and collaboration between Georgia's community mental health providers and the school districts in their service areas. From Year 1 to Year 4, the number of schools served by the Apex program grew 220 percent.

In FY15, DBHDD awarded **Transition Age Youth and Young Adult Supplemental Support Funds** (TAYYA-SFF) to six CCP's. These awards of $100,000 each were designed to increase cooperation and collaboration across agencies to meet the needs of TAYYA with serious mental health conditions and their families. These monies further the work of building infrastructure for non-billable time related to enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills that is not reimbursable through Medicaid or other funds. They support best practices, cultural competence, support services that assist youth with independent living address needs for housing, employment, education, basic living skills, and social support not supported by other funding. The expected outcomes were to improved access to services, effective services to assist with transitioning into adulthood and enhanced linkages and coordination of a non-clinical nature.

In FY 2016, a new Statement of Need (SON) was developed for **Emerging Adult Support Services** that was specific to the unique needs of the population and required goals to be achieved for individuals engaging in the grant. As a result of the new SON there were 11 grantees awarded $100,000 and through technical assistance was able to restructure programming to increase a seamless transition for young adults.

Emerging Adult Support Services (EASS) is designed to create developmentally-appropriate and effective youth-guided local systems of care to improve outcomes for emerging adults with serious mental health conditions in areas such as education, employment, housing, mental health, and co-occurring disorders, and decrease contacts with the criminal justice system. OCYF supports EASS grants to Comprehensive Community Providers and "Not for Profit" providers to meet the following objectives: 1) Increase and improve cooperation and collaboration across agencies to meet the multiple and complex needs of emerging adults with serious mental health conditions and their families; 2) Enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills; 3) demonstrate improving access and expanding the array of community-based, age-appropriate treatment, culturally and linguistically competent services and supports for emerging adults as well as their families. Each grantee has a unique referral process as well as programming, therefore it is recommended that an individual contact each respective organization for more information. In FY18, EASS merged into OCYF's state funded system of care programming.

In partnership with the Office of Federal Grant Programs and Cultural and Linguistic Competency, the OCYF is supporting implementation of the Listening, Inspiring, and Guiding Healthy Transitions, Early Treatment Program for First Episode Psychosis (LIGHT-ETP). The LIGHT-ETP provides Coordinated Specialty Care for young adults ages 16-30 who have recently begun experiencing symptoms of severe mental illness, specifically first-episode psychosis. The goals of LIGHT-ETP include early detection of psychosis; rapid access to coordinated, team-based, multi-element specialty care; evidence-based, recovery-focused interventions; and youth- and young-adult-friendly services that emphasize engagement, assertive outreach, and person-centered planning. The intended outcomes include a reduction in the duration of untreated symptoms and illness; reduction in unnecessary hospitalizations; and improved clinical, social, and academic/occupational functioning. The services offered by the multi-disciplinary LIGHT-ETP teams include psychotherapy, case management, supported education & employment, peer support, family support and education, and medication management, and /primary care coordination. More information on this program is in the Environmental Factors section of this plan.

DBHDD has also provided funding support to providers of child and adolescent mental health services for purposes of supporting activities that build on system of care infrastructure and support in local communities. In FY15 ($1.4M) and continued into FY16, DBHDD awarded **System of Care Enhancement and Expansion Funds (SOC-EEF)** to 15 Child and Adolescent Mental Health providers throughout the state. These awards, under contract, are used to support system of care value oriented in child and adolescent mental health. These monies further the work of building infrastructure for non-billable time related to family team meetings, LIPT meetings, and other consultative services with the other child serving agencies that are not reimbursable through Medicaid or other funds. They support best practices, cultural competence, training, outreach activities to engage families, Non-Medicaid, non-billable transportation to and from treatment related activities, snacks for consumers during groups and programming, community education activities on system of care work, and engagement activities with youth not supported by other funding. The expected outcomes are improved family access to services, and. enhanced linkages and coordination of a non-clinical nature. In FY18, EASS became one of the deliverables of SOC-EE.

OCYF has established **community innovation pilots/grants** to support existing or new behavioral health services, programs, or projects that assist OCYF with accomplishing its mission and add value to Georgia's public mental health system serving children, young adults and families. These organizations work within the System of Care (SOC) framework, to include values such as collaboration, strength-based, cultural competence, and family/youth voice/choice.

DBHDD received funding beginning in FY 2018 to implement a very limited crisis benefit for Autism Spectrum Disorders. The DBHDD Office of Medicaid Coordination is spearheading a collaborative project between the Division of Behavioral Health and the Division of Intellectual/Developmental Disabilities to implement an ASD Crisis Stabilization Unit (10 beds) as well as 2 ASD Crisis Support Homes (3 beds each). DBHDD, in its 2019 implementation of a new Mobile Crisis procurement, added ASD competency to the Mobile Crisis response expectations.

Substance Abuse Treatment and Prevention Services

Substance Abuse Treatment

The **Office of Addictive Diseases (OAD)** provides Core and Specialty Services. In addition, OAD continues to increase the array of treatment services available for youth with substance abuse issues. The services are: intensive residential treatment programs (IRTs) and the clubhouse recovery support services for youth. In addition, DBHDD funds two Adolescent Intensive Residential Treatment (IRT) Programs. The IRTs provide 24-hour supervised residential treatment for adolescents ages 13-17 who need a structured residence due to substance use disorders. The programs are located in the metropolitan Atlanta and in the southern part of the state. Currently there are fifty IRT beds for adolescent addictive disease treatment, fifteen beds allotted for females and the remaining beds for males. These two treatment centers have historically served youth that have both substance use disorders and SED related issues and are often used as a referral source by the juvenile court system.

The Clubhouse model, which is a recovery support services model combined with an evidence-based program for helping Georgia youth with substance use issues, was started by OAD in 2008 to create a safe and stable environment for youth. The clubhouse is a unique comprehensive substance abuse recovery support model that engages adolescents and their families to look at, and make changes in their lives in order to maintain a healthy and sober lifestyle. The model offers a unique way to engage and retain youth in services. The Clubhouse is a supportive environment where the youth are members. Staff and members work together to perform the tasks of the clubhouse and participate in social outings, educational supports, employment supports, nutrition education and other specific clubhouse activities.

There are nine substance use recovery support clubhouse programs throughout the state of Georgia providing services to youth with a primary substance use diagnosis including one clubhouse program providing services to youth with co-occurring issues. Additionally, one of the clubhouse programs provides recovery support services that focus on the needs of the Latino population.

Prevention Services and Programs

The **Office of Behavioral Health Prevention (OBHP)** supports the health and well-being of individuals, families and communities by reducing the use and abuse of substances and their related consequences across the lifespan, and delaying the onset of substance use by youth using a data-driven planning process that targets high priorities for all categories of the population defined by the Institute of Medicine.

In February of 2015, OBHP re-organized to reflect some of these common linkages and shared risk and protective factors with Substance Abuse and Suicide Prevention, and Mental Health Promotion. OBHP utilizes a public health approach (population based) and the Strategic Prevention Framework Model (Assessment, Capacity, Planning, Implementation and Evaluation). OBHP's infrastructure is set up as the Georgia Strategic Prevention System (GASPS). OBHP operates as the central decision-making authority that executes services through a community contracted providers, partners, and community coalitions. Planning and operations are conducted with input and collaboration of a Community Advisory Council (CAC) and State Epidemiological Outcomes Workgroup (SEOW). The CAC includes Community Representatives, Key Informers, and Beta Testers. The SEOW includes data stakeholder Agencies' Epidemiologist, Statisticians, Data Coordinators, Evaluators, Agency Directors, and representatives (representing organizations such as Dept. Of Education, Public Health, GA Corner's Association, Medical Association of Georgia, Georgia Drugs and Narcotics Agency, and others).

Currently there are 16 projects under the Substance Abuse Prevention segment of OBHP. They include: Alcohol & Substance Abuse Prevention Project (ASAPP), 3 Prevention Clubhouses, A Governor's Red Ribbon Campaign, SYNAR Tobacco Compliance (with GA DOR), GA Prescription Drug Abuse Prevention Collaborative (GADAPC), Drugs Don't Work Program, Partnerships For Success II (GenRx) Prescription Drug, Maternal Substance Abuse (MSA) Child Development Project, Georgia Teen Institute, Voices For Prevention (V4P), and GASPS Data Warehouse Project, and under the Targeted Response to the Opioid Crisis Grant there is a Statewide Media Campaign for addressing Opioid Misuse and Abuse, Four SPF Opioid Pilot Projects, a School Transition Mentor Pilot Project, and a Naloxone Education and Training Program.

Substance Abuse Prevention Projects: The **ASAPP Project** is a statewide initiative aimed at preventing alcohol and identified substances of abuse and promoting healthy lifestyles and choices among Georgians. Based on epidemiological data early onset of alcohol use and abuse and binge drinking have been identified as major public health and safety issues in Georgia. The objective of ASAPP is to implement evidence-based prevention strategies (programs/practices/policies) targeting the state's identified priority need, Alcohol and to allow communities to address a second local priority need identified using local data. The project

requires all providers to participate in a state level evaluate and all providers to conduct and share results of their local community evaluation. This is based on a Strategic Prevention Model (SPF) and a public health approach to determine effectiveness of strategies for different communities for producing and sustaining successful outcomes and allow OBHP to use data to drive future prevention decisions and efforts. The following are the State's Primary goals around Alcohol:

1) Reduce the early onset of alcohol use among 9-20 year olds
2) Reduce access to alcohol and binge drinking among 9-20 year olds
3) Reduce binge drinking and heavy drinking among 18-25 year olds

Providers are also required to join with community coalitions and developed Community Prevention Alliance Workgroups (CPAW) to effectively implement the strategies and garner community buy-in for accomplishing the goals.

OBHP believes this approach will result in and centers on communities developing and implementing sustainable outcome-based prevention strategies.
https://dbhdd.georgia.gov/alcohol-prevention-project-0

The Drugs Don't Work Program is designed to help employers become certified drug-free workplaces by establishing employee assistance programs and drug-free workplace policies.
http://dbhdd.georgia.gov/drugs-dont-work-georgia

The **HODAC Helpline** is a confidential first step for families, friends, employers or the addicted individual. Trained, caring telephone information specialists are available 24-hours a day, seven days a week to provide information about addictive disease, alcohol and other drugs; treatment options; locations of treatment facilities and self-help organizations, DUI Risk Reduction programs, drug laws, etc.
http://www.hodac.org/

The Georgia Prescription Drug Abuse Prevention Collaborative (GADAPC) focuses on four priority areas to prevent and reduce prescription drug abuse in Georgia. The four areas addressed are those that have been identified by the Office of National Drug Control Policy: education, monitoring, proper medication disposal, and enforcement. It is composed of public and private sectors, to work collectively in Georgia to address the priority areas listed above.

The Generation Rx (GEN Rx) Project is a response to the growing epidemic of prescription drug abuse among youth and young adults in Georgia. The objective of GEN Rx is to implement evidence-based strategies to reduce prescription abuse among 12 – 25 year olds within the targeted areas of Catoosa, Early and Gwinnett counties. The project is funded by the OBHP/

DBHDD through a Federal SAMHSA (Substance Abuse and Mental Health Services Administration) grant.

Strategies:
The primary strategies implemented by the GEN Rx project are Education, Proper Medication Disposal, and Enforcement. Education**:** Educate Georgia's parents, youth, the general public, physicians, pharmacists, elderly adults and their caregivers, etc. about the dangers of prescription drug abuse and the appropriate use, proper storage and safe disposal of prescription drugs. Proper Medication Disposal**:** Encourage convenient, environmentally responsible and safe prescription drug disposal programs to decrease the supply of unused prescription drugs in the home. Enforcement**:** Collaborate with law enforcement to eliminate improper prescribing practices as well as prevention "pill mills", "doctor shoppers", and other similar drug-seeking behavior.
http://genrx.us/

The Georgia Strategic Prevention System (GASPS) Data Warehouse is an innovative response to Georgia's need for evidence-driven, outcome-based substance abuse prevention. The GASPS warehouse is an online repository containing a wealth of information on substance abuse, its consequences, and related social indicators. The GASPS data warehouse is created using interactive and innovative data visualization software called Tableau Public, which is fully integrated with social media platforms, allows users to interact and customize their data experience, and creates visually stunning charts, graphs and maps that will update in real time on our providers' websites. County-level data in our warehouse includes student health surveys, substance abuse-related arrests, traffic morbidity and mortality, vital records information, child wellness indicators, and substance abuse treatment admissions. The online site has been developed by the OBHP through a contract with the University of Georgia, Carl Vincent Institute.
www.gaspsdata.net

The Georgia Teen Institute is a youth leadership program for Youth Action Teams throughout Georgia that begins with a summer training program and continues with year-round support. Youth teams attend a four-day residential camp held at Oxford College to develop leadership skills and engage in the Strategic Prevention Framework planning process through workshops, team meetings, and team building activities. The teams work to plan and implement peer-focused substance abuse prevention and community service projects. GUIDE follows up throughout the year with additional training and technical assistance, networking meetings and monthly reports outlining teams' actions and activities.
http://guideinc.org/what-we-do/georgia-teen-institute/

Maternal Substance Abuse and Child Development Project (MSACD) is committed to raising the awareness of the devastating effects of alcohol and other substances when used during pregnancy. MSACD collaborates with Georgia's Alcohol Prevention Providers and their communities in all six of Georgia's regions to raise awareness about alcohol and substance abuse among pregnant women. MSACD has currently established relationships with at least one community in every region across the state. Collaborations have included media messages on maternal substance abuse during pregnancy and supplying resources addressing the use of any substance. Trainings on maternal substance abuse, child development, alcohol and other drug related effects are conducted for prevention providers. MSACD also presents at and participates in state prevention conferences such as the Georgia School of Addiction Studies and the Summit on Youth Issues.
http://www.emory.edu/msacd/

The Minimum Data Set Version 2.0 (MDS) is OBHP's online reporting system for the capture of block grant prevention process service data across the state. The MDS system enables OBPH to quantify and compare the numbers and types of primary substance abuse prevention and early intervention services delivered throughout the state of Georgia. This data is also utilized in reporting Block Grant data to SAMHSA.
https://www.geprgoa,ds/uga.edu

The OBHP funds three very innovative and unique **Prevention Clubhouses** that were designed to provide prevention services to high risk youth ages 12-17 to address socio-economic ills and risk factors they face in their communities at home. They are located in Norcross, LaGrange and Dawson, Georgia. Each Prevention clubhouse is unique and diverse serving the population in that immediate community. Participation is limited to youth who are at high risk for alcohol and drug abuse, involved in ongoing detention and/or alternative school, parent(s) have current or past addiction, sibling(s) currently receiving treatment for substance abuse disorder or experiencing education or social issues.

The clubhouses use peer mentors, evidence-based prevention curriculums, and interactive engaging youth activities to build coping, decision making, and life skills. They each include family activities/participation, community service, education and employment services, nutrition, physical activities and an evidence-based prevention curriculum. The clubhouses provide a safe, comfortable and exciting place for the youth they serve.
https://dbhdd.georgia.gov/prevention-clubhouses

The **Red Ribbon Campaign** is a media and activity driven strategy aimed at building general population (universal) awareness of the importance of a drug free lifestyle. Each year, schools and communities are encouraged to develop messages and activities to demonstrate their commitment to living drug-free lifestyles in a competition for prizes.

SYNAR compliance is contracted with the Georgia Department of Revenue. In July 1992, congress enacted the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (P.L 102-321), which included the Synar Amendment (named for its sponsor, Congressman Mike Synar of Oklahoma

- The goal of the Synar Amendment is to reduce the number of successful illegal tobacco purchases by minors to no more than 20 percent of attempted buys
- Amendment calling for state to enact and enforce laws preventing the sale of tobacco products to minors.
- Require conducts of an annual coverage study
- Requirement of the SAPT BG
- Georgia's 2010 (2009 investigations) Synar non-compliance rate+ 9.8%

The SYNAR amendment requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under the age of 18 and to enforce those laws effectively. OBHP contracts with GA DOR to conduct retailer tobacco compliance checks across the state.
http://georgia.gov/agencies/georgia-department-revenue

The mission of **Voices for Prevention (V4P)** is to build a unified statewide voice for substance abuse prevention by collaborating with a diverse group of prevention specialists, service providers, community coalition members and individuals with an interest in and a commitment to substance abuse prevention. This mission will be accomplished by advocating and educating on substance abuse and related issues.
http://v4pga.org/about-us/

The Georgia State Targeted Response to the Opioid Crisis (STR Opioid) Project is a SAMHSA grant for developing a targeted response to the opioid crisis, in Georgia, through prevention, treatment, and recovery initiatives. Prevention programs consist of 4 components. 1) A Statewide Media Campaign to increase awareness about opioid misuse and abuse, provide education about the problem and available resources, reduce stigma, and increase awareness and understanding of the Good Samaritan Law. 2) A Naloxone Education and Training component will provide Naloxone/NARCAN training for first responders and people in the community (ambulance drivers, emergency room professionals, fire fighters, police officers, community service boards, etc.). 3) A School Transition Mentor Program will develop an opioid prevention education program & tool kit for use across key transitional periods. 4) Lastly, a SPF Pilot Program will increase the number of SPF prescription drug prevention providers in Georgia, with an opioid focus.

Suicide Prevention: Current there are 4 projects under the Suicide Prevention segment of OBHP. They are: Community and Agency Suicide Education & Training Project, Training and Technical Support of House Bill 198 (Jason Flatt Act), Promotion and Support of DBHDD's Policy 01-118, Maintaining the Georgia Suicide Prevention Information Network (GSPIN), and implementation of the Garrett Lee Smith Youth Suicide Prevention Grant.

The newly added Mental Health Promotion segment of OBHP is currently under Strategic Planning for incorporation throughout OBHP's work. A "Spot the Signs" Media Campaign to raise awareness, reduce stigma, and improve communications for appropriate referrals is underway.

The current DBHDD/OBHP suicide prevention effort is staffed with the state Suicide Prevention Program Coordinator, a Suicide Prevention Specialist, and a Garrett Lee Smith Coordinator. Georgia received its third SAMHSA Garrett Lee Smith Youth Suicide Prevention Grant in September 2015. The federal Garrett Lee Smith Youth Suicide Prevention (GLS) Program focuses on developing comprehensive suicide prevention programs within schools.

The first GLS grant program included gatekeeper training for school staff and developing protocols and referrals for getting young people at risk of suicide to help as well as training schools in best practices in intervention and postvention. It also included an innovative youth peer support model, Sources of Strength, which was introduced to school systems that had a suicide rate higher than the national average. Through the project, over 850 Adults were trained as gatekeepers and over 600 youth were trained as peer leaders. Twenty-two thousand students were exposed to positive messaging activities and named over 1000 trusted adults in their schools and communities.

The second GLS YSP Grant, focused on serving 15 counties, 16 targeted school systems and 39 schools. A comprehensive Suicide Prevention Program was developed that included: Suicide Prevention Protocols, QPR training for 85% of the staff, Lifelines Training - Intervention and Postvention, an enhanced Gatekeeper Sources of Strength Program, Sustainability Plans, Early Identification and Referrals, networking with local Suicide Prevention Coalitions to create linkages of sustainability, and, promotion of the Georgia Crisis and Access Crisis Line and National Lifeline in English and Spanish. Through contracts with nonprofit organizations and Mental Health provider's specific populations were targeted: CETPA served the Latino population in Gwinnett County; the Community Service Board of Middle Georgia served rural populations; the Southern Jewish Resource Network, Inc. (SOJOURN) served the LGBTQ community by providing awareness workshops to the community; clergy; and, the Suicide Prevention Coalitions statewide. There was also a contract developed with Camden Community Alliance & Resources, Inc. to help reach military families and their children. Through all the above projects, over 3,000 adults were trained as gatekeepers and over 1,600 youth trained as

peer leaders. 33,330 students were exposed to positive messaging activities and named over 5,000 trusted adults in their schools and communities.

Through this grant, DBHDD/OBHP also implemented the Sources of Strength Program at 6 universities: Ft. Valley State University, Savannah State University, University of West Georgia, Savannah College of Art and Design Savannah and Atlanta Campuses and Georgia Highlands College. Two of those were Historically Black Colleges and Universities (HCBUs). With the guidance of the Sources of Strength Team the Sources of Strength curriculum was adopted for colleges/universities students and a University Program Manual was created. The Sources of Strength developer and the GLS project director provided on-site technical support and training to the Sources of Strength Teams at each campus each year. The Sources of Strength Team at each university also developed a series of activities focusing primary on suicide prevention and wellness impacting many areas creating collaboration with several organizations, associations, programs within their campuses.

The GLS YSP grant program also co-sponsored the Suicide Prevention College Conference the 4th year. The purpose of the conference was to introduce colleges to suicide prevention as a public health issue and exchange ideas on working with special populations, engaging stakeholders, developing policy, screening, use of evidenced based practices in prevention; developing coalitions, stigma reduction, Sources of Strength peer program, and gatekeeper training. Two hundred and seven individuals attended representing 37 colleges/universities. In addition, the project partnered with 25 organizations.

The project also offered a comprehensive training package that included: QPR gatekeeper training; Annual Professional Seminar Series on Critical Issues Facing At-Risk Children; Assessing and Managing Suicide Risk; Counseling on Access to Lethal Means; Working with Those Bereaved by Suicide in the Professional Setting: Postvention Strategies; Mental Health First Aid; and suicide prevention toolkits for primary care physicians impacting over a 1,000 professionals annually in communities throughout the state and delivered 75 Suicide Prevention Toolkits for Rural Primary Care and Pediatric and Family Care.

The most current GLS grant, the *Georgia Suicide Safer Communities for Youth Project* focuses on youth ages 10 to 24 years living in three Georgia counties (Bartow, Newton and Oconee) with youth suicide death rates higher than the national average of 8.02 for the years from 2011 - 2013. Selected populations of focus include African American youth, youth suicide attempters, and family members of youth who have been identified with suicidal ideation or a suicide attempt. Community assessments in each county helps identify county specific populations of focus. It is estimated that 1,000 will be served annually and 5,000 over the life of the 5-year project.

We are currently in Year 2 of the 5-year project. Through our work in the first two years, we have identified the need for youth suicide prevention efforts in the surrounding areas of the counties that were originally identified with high youth suicide death rates. Because of the youth suicide deaths in the surrounding areas, the GLS grant will expand to meet the needs of youth suicide within the whole agencies involved in the project starting Year 3. Those three sub-grantees are Advantage Behavioral Health, Highland Rivers Health and View Point Health. The *Suicide Safer Communities* project is guided by 5 of the 13 National Strategy for Suicide Prevention goals and their objectives, including: Goal 1: Develop, implement, and monitor effective programs that promote wellness and prevent suicide related behaviors. Goal 2: Provide training to 3,500 community and clinical service providers on prevention of suicide and related behaviors. Goal 3: Promote suicide prevention as a core component of health care services. Goal 4: Promote and implement effective clinical and professional practices for assessing and treating 1,500 youth identified as being at risk for suicidal behaviors. Goal 5: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

As a part of larger funding issued to The Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD) through the Garrett Lee Smith federal funding from September 2015 through September 2020, The College and University Coalition, made up of over 30 institutions of higher education including technical schools and public and private colleges and universities, is included in the Georgia Suicide Safer Communities for Youth Project.

Under this project, The Georgia College and University Suicide Prevention Coalition will provide a yearly Suicide Prevention Conference for Colleges and Universities, three additional suicide prevention training opportunities a year and assessment, data collection, tracking and evaluation services for the College Coalition. The Georgia College Suicide Prevention Coalition (College Coalition) will oversee targeted college and post-secondary education efforts. The efforts of Georgia's colleges and universities are included in the GLS goals to serve 5,000 youth and their families over the life of the 5-year project.

Mental Health Prevention Projects: OBHP is developing plans for incorporating Mental Health Promotion throughout OBHP work. OBHP is developing a "Spot the Signs" PSA to raise awareness, reduce stigma, and improve communications for appropriate referrals.

Criterion III: Children's Services: System of Integrated Services

Georgia does not have one agency responsible for all children's services. There are eight state agencies responsible for service delivery to children and their families. All agencies must work together to provide a system of care for children and youth with SED. DBHDD is only

responsible for provision of services to youth and their families requiring public behavioral health services who are uninsured, receiving adoptive services or disabled. The Department of Community Health (DCH) is responsible for behavioral health services to youth and their families who are Medicaid eligible due to poverty, in the custody of child welfare or committed to the DJJ. The Department of Human Services (DHS) is responsible for child welfare and regulatory services for residential child caring institutions. The Department of Juvenile Justice is responsible for probation, detention services and residential services for youth involved with juvenile justice. The Department of Public Health is responsible for county-based health services and early intervention services. The Department of Education is responsible for education services provided under IDEA to youth with SED. The Georgia Vocational Rehabilitation Services Agency is responsible for transition services for youth age 14-21. The Department of Early Care and Learning (DECAL) is responsible for Head Start Programs and other services to children 0-3 years old. The services provided by the primary child-serving agencies are discussed below.

Child Welfare

The Division of Children and Family Services (DFCS) under DHS provides Prevention, Safety (child protective services), Permanency (foster care, adoption, and kinship), and Well-Being (education, physical and mental health, and youth development) Services. Most of the children receiving these services have experienced the trauma of neglect or physical, emotional or sexual abuse; and a significant portion of them are youth with severe emotional disorders (SED). DFCS provides mental health services to youth with SED through referrals to DBHDD providers or to the private sector. In addition, some foster care funds are used for the Preventing Unnecessary Placement (PUP) Program, and can be used to purchase alternative Support and In-home services to prevent the need for removal of children from their homes. DFCS also works with community-based agencies providing a variety of services to children and families through the Promoting Safe and Stable Families (PSSF) Grant. This Program provides funding for the purchase of family support, family preservation, time-limited reunification services and adoption promotion and support services to ensure the safety, permanency and well-being of children. Another program, Intensive Community Support Program (ICSP) enables DFCS, foster caregivers, and community partners to think outside of mainstream therapeutic services which could assist a child in maintaining stability in a home, transitioning out of a more restrictive setting like a Psychiatric Residential Treatment Facility (PRTF), or reunifying with family.

DFCS also provides for a comprehensive assessment of youth entering foster care through the Comprehensive Child and Family Assessment (CCFA)process. This process focuses on early and continuous assessment of the strengths and barriers faced by children and their families, case plan development with the family and the use of a full continuum of services that best meets the unique needs of children in the least restrictive setting possible. A recent change to the mental health component of the CCFA is the replacement of a full-scale psychological evaluation with a

trauma assessment within the first 25 days of coming into foster care. It is known that the reasons that children are removed from family are based on neglect and abuse, however in addition they must cope with a change in their home environment, school environment and everything that is known to them. Having a psychological evaluation completed so soon after removal may not yield results that are true to the needs of that child. The purpose of the trauma assessment is to instead identify the experiences that that each child has had which may be considered traumatic or stressful and how he or she is functioning. If additional mental health assessments are required, then they are provided as well. DFCS continues to seek community-based services available to address the behavioral health needs of children and youth in care. Partnerships with state and community level providers supports the need for workforce development and research and training in evidence-based modalities.

Juvenile Justice

The Department of Juvenile Justice (DJJ) provides services to emotionally disturbed youth offenders and their families. Every youth confined in a secure facility is screened for possible mental health problems, trauma, substance abuse problems and suicide risk. If screening does suggest a need for mental health services or suicide precautions, the youth is referred for a mental health assessment. Every youth committed to DJJ and placed in a secure long-term secure facility receives a mental health assessment by a qualified mental health provider within ten days of admission. Youth who are assessed and determined to need mental health services are then treated in accordance with a treatment plan developed by a multidisciplinary treatment team.

The DJJ Office of Behavioral Health Services is responsible for mental health services for youth detained in any of the agency's short-term Regional Youth Detention Centers (RYDCs) and long-term Youth Development Campuses (YDCs). Georgia DJJ currently operates 19 RYDCs and 7 YDCs.

Youth committed to DJJ are also served in non-secure settings. DJJ purchases residential placements from providers who offer RBWO and utilizes DBHDD state funded and MRO providers of behavioral health services when youth who are not enrolled in the Medicaid Managed Care Program. DJJ also accesses PRTF services for committed youth or DJJ involved youth as needed.

Education

The Georgia DOE ensures that all eligible children with disabilities have available to them a free and appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs. A child may be determined eligible for special education services for autism spectrum disorder, deaf-blind, deaf/hard of hearing, emotional and behavioral disorder, intellectual disability, orthopedic impairment, other health impairment, significant

developmental delay, specific learning disability, speech-language impairment, traumatic brain injury or visual impairment.

Special education is specially designed instruction provided at no cost to parents and may include instruction in the classroom, in the home, in hospitals, institutions and other settings. Instruction may include academic instruction, physical education, travel training, vocational education and related services. Related services are services such as transportation and developmental, corrective, and other supportive services as are required to assist a child with a disability to fully benefit from special education.

An Individualized Education Program (IEP) is developed by an IEP Team for each student receiving special education services. The IEP Team includes the parents of the child, at least one regular education teacher, at least one special education teacher and a representative of the Local Education Agency (LEA) and may include an individual who can interpret instructional implications of evaluation results, other individuals who have knowledge or special expertise regarding the child and whenever appropriate, the child with a disability. The IEP documents the child's present levels of academic achievement and functional performance, measurable annual goals and a statement of the special education and related services and supplementary aids and services to be provided to the child. The IEP must be in effect at the beginning of each school year and must be reviewed periodically, but not less than annually to determine whether the annual goals for the child are being achieved.

Supporting the 186 school systems in Georgia, the Georgia Network for Educational and Therapeutic Support (GNETS) provides comprehensive special education and therapeutic support for the children served. The purpose of the GNETS is to prevent children from requiring residential or other more restrictive placements by offering comprehensive services in local areas. Twenty-four GNETS programs may serve children ages 3 through 21 years in GNETS classrooms, with direct therapeutic services, evaluation and assessment or other services as appropriate. An IEP Team may consider in-class services by a GNETS program for a child with an emotional and behavioral disorder based upon documentation of the severity of the duration, frequency and intensity of one or more of the characteristics of the disability category of emotional and behavioral disorders (EBD).

Since 2008, GA DOE has been an active Positive Behavior Intervention Supports (PBIS) state as recognized by the national Technical Assistance Center on PBIS. PBIS is an evidence-based approach that provides schools with a framework for implementing effective prevention and intervention strategies. The goal at the GA DOE is to support high fidelity implementation of PBIS in schools across the state. The GA DOE PBIS team facilitates district-level planning and provides school team training, technical assistance and ongoing coaching to district coordinators in order to build capacity and support the PBIS process. The types of schools trained have been

Elementary (54%), Middle (23%), High School (13%), Juvenile Justice School and Alternative Schools (11%). Almost 400 school teams have been trained. The GA DOE recently convened a meeting of key stakeholders to inform the development of a state plan for proactively addressing climate, safety, and discipline in Georgia schools through utilization of PBIS. The Director of the DBHDD Division of Behavioral Health and of Children, Young Adults and Families participated in this two-day meeting. With support from state leadership, GA DOE hopes that resources and strengths will be aligned and coordinated to develop next steps to make PBIS available to all Georgia schools.

Georgia Project AWARE (GPA), funded by the Substance Abuse and Mental Health Services Administration, is designed to make schools safer and increase access to mental health services for children and youth. The GPA grant provides the structures and training resources needed to provide mental health services to underserved students in three local school districts: Griffin-Spalding County Schools, Muscogee County Schools, Newton County Schools. GPA is working to provide school-based and community-based resources to support students and families with mental health needs. Both the State and the participating school districts have made an excellent start in addressing the mental health needs of children, youth, families and caregivers. The multiple components of the project including universal mental health screenings, a mental health referral process, Youth Mental Health First Aid (YMHFA) and school-based mental health services. GPA provides local communities with increased access to school and community-based mental health services. The three school districts have made important gains in their efforts to increase awareness of mental health problems and strategies that can help to prevent such problems in the three communities associated with these three school districts and throughout the state of Georgia. GPA has worked collaboratively with DBHDD's Apex project and trained together on the Interconnected Systems Framework (ISF), an integration of mental health into the Positive Behavioral Interventions and Supports framework.

YMHFA trains school personnel, emergency first responders, and other adults who interact with school-aged youth to detect and respond to mental illness in children, youth, and young adults, including how to encourage adolescents and families experiencing these problems to seek and obtain treatment. This program will sunset in September 2019.

Vocational Rehabilitation

The Vocational Rehabilitation Program within the Georgia Vocational Rehabilitation Agency collaborates with DBHDD to provide evaluation, training, and other individualized services that are needed to help consumers obtain and maintain employment. VR staff exchange referrals with mental health provider staff and help link consumers with education, job training, and employment opportunities. Additionally, VR effectively works with schools and other agencies to assist students with disabilities who are transitioning from high school to post-school activities to include employment through the provision of coordinated services such as guidance and

counseling, training and job placement. Furthermore, VR has committed to assist with planning for older youth in residential settings who need training and employment.
VR continues to investigate best practices in removing systemic barriers, through partnerships with DBHDD, and other agencies interested in quality employment outcomes.

Public Health

The Georgia Department of Public Health (DPH) provides services through 18 administrative public health districts and local health departments in all 159 counties. DPH's main functions include: Health Promotion and Disease Prevention, Maternal and Child Health, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records, and the State Public Health Laboratory.

A close relationship exists in most areas between local public physical health and mental health services. Referrals from behavioral health centers to county health departments are common, especially for routine health/developmental screening and immunizations. Older youth with multiple needs are served through Public Health's Children's Medical Services Program. Younger children at risk of emotional disturbance served through the Babies Can't Wait (BCW) Program, Georgia's Part C Program. Georgia continues to promote programs to encourage Early Periodic Screening Diagnosis and Treatment screenings in Georgia.

The DPH State Office includes the Division of Health Promotion's Maternal and Child Health Section (MCH), which is responsible for the Title V Block Grant. The Title V toll-free hotline, PowerLine, assists parents, health care providers, social service agencies, community organizations, and any other individual or agency experiencing difficulties in obtaining information about health care and/or health care services. PowerLine provides referrals for Babies Can't Wait (BCW), PeachCare for Kids, and Children 1st and maintains Georgia's most comprehensive database of physicians and clinics that accept Medicaid and PeachCare, reduced fees, and/or low-cost fees.

Children 1st is the "single point of entry" to a statewide collaborative system of public health and other prevention-based programs and services. Through a systematic process, children are identified, their risk factors are screened, and children with sufficient biological, social, and/or emotional risk factors are linked to appropriate public health programs and community-based resources. Children who do not present risk factors severe enough to qualify for an early intervention program remain in Children 1st where they are linked directly to a medical home and monitored to ensure that if sufficient risk factors do arise, the identification, screening, and placement in an early intervention program can occur as quickly as possible. Children 1st refers families to other public health programs as appropriate, including BCW and Children's Medical Services (CMS). Linkages are made to Medicaid and PeachCare for Kids as appropriate.

Under the MCH Office of Child Health, the Children and Youth with Special Healthcare Needs' (CYSHN) focus is to provide program development, leadership, guidance, and resources to Georgia's 18 Health Districts in the development and provision of a comprehensive, integrated, and coordinated system of services for children and youth with special needs, birth to age 21 and their families. CYSHN includes Early Intervention Services (Babies Can't Wait) and Children's Medical Services (CMS).

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. BCW supports a toll-free number for individuals with disabilities, families of children with special needs, and professionals that provides a special needs database/directory of over 5,000 public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at risk for developmental delays or disabilities. In addition to obtaining information about services, hotline callers can be matched with supporting parents whose children have similar disabilities. The DPH BCW team also collaborates with the DCH and DBHDD in the development of newly-funded ASD services and supports, serving as collaborative subject matter experts to one another as each implements aspects of the Georgia plan for youth ASD services.

The purpose of Children's Medical Services (CMS) is to ensure that there is a community-based, coordinated, family focused, culturally appropriate, comprehensive system of quality specialty health care services available for Georgia's children with chronic medical conditions from birth to 21 years of age and live in low-income households. CMS provides care coordination, specialty medical evaluations and treatment for eligible children and youth who have complex medical conditions. Core CMS services include care coordination with a comprehensive plan of care, assurance that a child has a medical home with a primary care provider, and transition planning for youth ages 16 to 21 years of age.

DPH also provides for dental services for children and youth. The public health dentists and dental hygienists serve children with Medicaid/PeachCare for Kids; low income, uninsured children in need of oral health care; and special needs children. The Oral Health Program has 18 districts throughout the state with some type of school-based or school-linked oral disease prevention program. Referrals to dental providers serving populations with advanced special health care needs are available from the dental public health providers and the State Oral Health Program. The Oral Health Program has developed a statewide referral database for children with special needs.

DPH's Division of Health Protection includes the Chronic Disease Prevention Section which is

responsible for implementing population-based programs and services focused on chronic disease prevention and promoting healthy behaviors and includes the Office of HIV/AIDS' HIV Care Ryan White Part B Program and the Tuberculosis Prevention and Control Program.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a SAMHSA funded grant, continues efforts to increase access to screening, assessment, and referral for appropriate services for children ages 0-8 in Muscogee County. DBHDD is partnering with the Department of Public Health (DPH) to implement the strategic plan. The project is in year 5 of 5 years, and is currently focused on increasing mental health screening of young children in the school and early education settings using the ASQ and ASQ – SE (Ages and Stages Questionnaire – Social Emotional Assessment), increasing outreach to pediatricians to include mental health screening in their processes, and training the young child workforce on the social emotional development of young children. These goals are being accomplished through many local partnerships and the project has been able to establish many family, physician and community service champions.

Project LAUNCH Georgia addresses three main **goals**: (1) expand early identification and linkage of children at-risk for social-emotional and behavioral delays to provide timely support for children and parents, (2) increase the capacity of providers of Muscogee County who serve young children and to provide integrated comprehensive behavioral health services and (3) build common infrastructure between child serving agencies at the state and local levels.

Sustainability plans are being finalized for Project LAUNCH through several partnerships and new funding streams. Some examples include, the new program LENA Start, a program for parents to increase language nutrition for their young children through training and a vest that the child wears to count the words he/she is learning throughout the day. This program has been embraced by the Muscogee County community with parents already enrolled and participating in the program reporting positive results. Another funding stream identified is a grant that the Department of Public Health applied for, Healthy Start. This grant will allow home visiting to expand in Muscogee County and also supports a fatherhood initiative and healthy mother/baby programs. Reach out and Read is also expanding in the Muscogee County area, through the support of new partnerships formed through Project LAUNCH, which will continue to provide literacy tools for physician offices. Help me Grow is a Department of Public Health initiative to better connect families with services across Georgia that has also been supported by Project LAUNCH efforts.

State Efforts to Develop Systems of Care

DBHDD has been leading this system of care development for over 30 years. The initial efforts began with a federal grant, the **Child and Adolescent Service System Program**. Out of this effort was the establishment of local interagency (MATCH) committees; development of a

statewide family organization, the Georgia Parent Support Network (GPSN) which is Georgia's Federation of Families for Children's Mental Health chapter; and development of a State Strategic Services Capacity Building Plan that was used as the foundation for the first separate Children's Plan for the MHBG.

Even with service development and expansions as a result of the planning effort, DBHDD continued to hear from agency partners that child and adolescent mental health services were not available or adequate to meet the needs of youth and families. In response to specific concerns regarding access to mental health services DBHDD launched a **Quality Improvement Initiative** and contracted with Sheila Pires of the Human Services Collaborative in Washington, D.C. a well-known expert on Building Systems of Care to lead this initiative. The SOC QI Initiative provided the impetus and foundation for identifying needed service and system improvements and for initiating strategic planning to strengthen the infrastructure throughout the state.

In October 2004, Georgia was awarded a **Child and Adolescent State Infrastructure Grant** (CASIG) from SAMHSA to help expand the state's infrastructure for developing comprehensive systems of care to meet the needs of youth with SED, substance abuse, and co-occurring disorders and their families. This grant focused on building systems of care through workforce development; expansion of the youth and family voice in service design and delivery; development of financing strategies; and development of interagency mechanisms. DBHDD was also awarded a Substance Abuse Coordination grant from the Center for Substance Abuse Services in October 2005 and these efforts were integrated with the CASIG project.

In December 2006, Georgia received the **Alternatives to PRTF Demonstration Grant** from CMS as previously mentioned and described. This provided the opportunity to develop a best practice system of care approach to service delivery, High Fidelity Wraparound and establish Care Management Entities. In 2009, as aforementioned, Georgia received the **CHIPRA Quality Demonstration Grant** enabling DBHDD to evaluate and refine the CME model as well as develop the CPS-P and CPS-Y training and certification program further solidifying system of care approaches to service delivery.

In 2009, Georgia was one of seven states selected as a **SAMHSA Healthy Transitions Initiative (HTI)** grantee. The HTI grant was aimed at addressing the needs of transition age young people with mental health needs focusing on service, policy and infrastructure components. The goal was to improve outcomes for youth and young adults ages 16 through 24 with serious mental health challenges and to transition them to adulthood in areas such as education, employment, housing, and accessing mental health services. Two demonstration sites implemented the Transition to Independence Process (TIP) Model developed by Dr. Rusty Clark. This person- centered model uses transition facilitation coaches to assist young people in meeting their individualized transition plans.

A key component to successful transitions includes young adults accessing and consistently utilizing adult mental health services when needed. To assist in the transition from the child and adolescent system to the adult mental health system, the HTI grant brought these two systems together. DBHDD held internal meetings where policy leadership from both systems reviewed the current DBHDD Provider Manual and examined areas where transition language, planning and services could be added to the current spectrum of services and supports. To this end, DBHDD developed a policy, 'Best Practices for Serving "Emerging Adults" - Transitioning from Late Adolescence to Young Adulthood' and a toolkit for providers. In addition, DBHDD and the Georgia Vocational Rehabilitation Agency developed a MOU to support enrollment of young adults in IPS Supported Employment. The agreement provides funding and dedicated mental health VR counselors to serve adults and transition age youth and young adults (16-21) with mental health conditions.

In July 2013, DBHDD was awarded a five-year **System of Care Expansion Implementation Grant**. This grant, **Georgia Tapestry**, provides DBHDD, in partnership with other child-serving agencies, the opportunity to further implement infrastructure and services which support development of a more effective service delivery system. The project goals and objectives were derived from the initial IDT plan. The goals are to: Implement policy, administrative and regulatory changes; Develop or expand services and supports based on the SOC philosophy and approach; create and improve financing strategies; provide training, technical assistance and workforce development; and, generate support and advocacy.

Georgia Tapestry developed and funds two co-occurring clubhouses. The pilot project vision is to improve outcomes for youth and young adults ages 15 through 21 with serious mental health challenges and substance use issues by supporting areas such as education, employment, social skills and accessing mental health services through a co-occurring clubhouse model.

DBHDD remains committed to family and youth inclusion across all levels of service delivery and supports the workforce development of certified peer specialists (CPS). Recovery oriented SOC supports training for parents with lived experience as parents of youth with serious emotional disturbances (CPS-P). A separate curriculum was also developed for youth and young adults with lived experience navigating the behavioral health service delivery system (CPS-Y). Additionally, to support youth/young adult leaders with lived experience to grow into advocates, advisory partners and CPS, a Youth Leadership Academy has been developed and implemented. The Academy aims to promote the development of youth and young adult leaders through creating a learning environment designed to cultivate youth voice. It provides robust training, tools and activities to increase inclusion of youth in policy, governance and service delivery. It was designed to build capacity for potential youth candidates to become employed CPS and/or Youth MOVE leadership. In addition to family and youth support and advocacy development,

the grant initiative supplemented the expansion of family and youth service organizations, including local Federation of Families for Children's Mental Health chapters as well as Youth M.O.V.E. chapters state-wide.

Training and technical assistance is another area of concentration. Grant funding supported multiple training initiatives on relevant topics to support system of care efforts statewide. The Interagency Directors Team (IDT) and Local Interagency Planning Team (LIPT) chairs were trained by Dr. Vivian Jackson on *Cultural and Linguistic Competence at the Organizational and Systemic Levels* and Ellen Kagen from Georgetown University on Effective Leadership for Systems Change/System of Care Leadership. A two-day Trauma Informed Systems training, originally developed by the National Child Traumatic Stress Network, takes a strength-based approach to providing an understanding of how to recognize, approach and respond to children and families impacted by acute and complex forms of trauma. The curriculum is designed to teach basic knowledge, skills, and values about working with children who have experienced trauma and have been involved with any child serving system such as child welfare, education, or juvenile justice. Types of providers trained across all six DBHDD regions included clinical directors, juvenile probation or parole, clinicians, licensed professionals, and wraparound supervisors. The annual System of Care Academy was held this summer, *Celebrating Our Progress: Vision to Reality* was selected as this year's theme. The SOC Academy was hosted by DBHDD and the IDT and had over 500 attendees including community providers, child serving agencies, stakeholders, families and youth.

Local Efforts to Develop Systems of Care

The Peachstate Wraparound Initiative (aka, KidsNet Rockdale) was a Center for Mental Health Services grantee for the Child Mental Health Initiative. With federal support, this program demonstrated use of a system of care model in a suburban area of the state. KidsNet Rockdale expanded in their service area and to other sites in the state and supported development of systems of care in these areas. Technical assistance was provided to a wide variety of partners, including local juvenile courts in several counties; the Governor's Office for Children and Families; DJJ; other local areas interested in system of care development; and local universities. With the support of the Governor's Office of Planning and Budget, the DBHDD and DJJ, these sites were sustained beyond federal funding and became part of the broader Georgia System of Care development.

In October 2005, the former DHR launched a pilot to model system of care development in Savannah, Georgia. KidsNet Savannah developed coordinated service delivery approaches for youth with SED and their families and developed a System of Care Policy Council to oversee system of care development. DBHDD staff provided support in order to ensure integration with statewide development. The development of KidsNet Savannah also became the foundation for

the implementation for the roll-out of the PRTF Waiver Service Demonstration as well as the EAI Grant that was awarded to DBHDD.

KidsNet Northwest began their work with an interagency case management project focused on youth involved with juvenile justice with participation from public health, juvenile justice, and mental health and subsequently expanded services to youth and their families building on the model of KidsNet Rockdale. DBHDD provided support to attend national system of care training events for technical assistance and consultation as needed for development activities. KidsNet Northwest received a SAMHSA CMHS Child Mental Health Initiative grant in October 2008.

In FY10, KidsNet Rockdale and KidsNet Northwest re-tooled and re-branded their initiatives. They maintained system of care approaches to service delivery and also enhanced their SOC by receiving training to become Care Management Entities (CMEs) under CBAY.

State Efforts to Develop Interagency Structures to Support SOC Development
In the absence of a Children's Department, there are state, regional and local collaboratives in place to support system of care development.

A State Level Children's Behavioral Health Service Collaborative was initially formed to oversee the implementation of the goals and objectives of the CASIG. The Collaborative received training on development of systems of care for youth that included information on lessons learned from federally funded local systems of care as well as information from developing local systems of care in Georgia. The State Collaborative known as KidsNet Georgia, developed consensus for and began steps toward meeting a strategic plan to build the system of care infrastructure needed for behavioral health service delivery to youth and their families. The Collaborative focused on four areas: Family and Youth Involvement, Financing, Interagency Collaboration and Workforce Development.

With the end of the CASIG grant, the functions of this group were sustained through the formation of the Interagency Directors Team (IDT) created by DBHDD in May 2011. The IDT is the state's multi-agency SOC leadership collaborative, whose mission it is to manage, design, facilitate and implement the SOC in Georgia. The IDT is a sub-committee of the Behavioral Health Coordinating Council (DBHDD) (OCGA 37-2-4). The membership consists of state agency representatives as well as partner organizations. The state agency partners include the Georgia Departments of Behavioral Health and Developmental Disabilities, Community Health (State Medicaid Authority), Early Care and Learning, Education, Human Services (Child Welfare), Juvenile Justice, Public Health, and Vocational Rehabilitation. The partner organizations include the four Care Management Organizations under contract with DCH; Amerigroup Community Care, CareSource, Peach State, and WellCare. In addition, three

provider associations; Georgia Association of Community Service Boards, Georgia Alliance of Therapeutic Services for Children and Families, and Together Georgia. Also, three family/children's advocacy/support organizations: Georgia Parent Support Network (the State Federation of Families for Children's Mental Health Chapter), Voices for Georgia's Children and Mental Health America of Georgia. There are two Georgia State University partners: Center of Excellence for Children's Behavioral Health (COE) and Center for Leadership in Disability. The remaining partners include the Get Georgia Reading Campaign for Grade Level Reading and The Carter Center. Lastly, the Centers for Disease Control and Prevention (CDC) serves as a consulting member.

The IDT initially adopted the following strategies to guide its work:

- Develop and expand services and supports, while focusing on individualized approaches to care management
- Create and improve financing strategies
- Provide training, technical assistance, and workforce development
- Generate support and advocacy
- Implement policy, administrative, and regulatory changes
- Use evaluation to continuously improve the system

These strategies were based on nationally recognized system of care development strategies.

The IDT more recently has sharpened its focus and has worked on development of a state System of Care Plan. Over 15 months (March 2016– May 2017), under direction of the Behavioral Health Coordinating Council (BHCC), and with the support of the Center of Excellence for Children's Behavioral Health and the National Training and Technical Assistance Center for Children's Behavioral Health, the IDT developed the 2017 Georgia SOC State Plan. Children, adolescents, and emerging adults with SED are the focus of the plan. The IDT identified the five focus areas of this plan: **Access**, **Coordination**, **Workforce Development**, **Funding and Financing**, and **Evaluation**. **Access** and **Coordination** were deemed the most critical areas of focus. **Workforce Development** and **Funding and Financing** strategies can be conceptualized as methods through which to increase **Coordination** and **Access**. **Evaluation** wraps around the entire plan, and feeds back into future planning efforts. Each focus area is aligned to a goal as well as short- and long-term strategies for achieving these goals. Below is excerpt from the Georgia System of Care State Plan 2017 which describes the focus of each area of these areas.

Access to an array of community-based services and supports is a core component of any functional behavioral health care system. For children and emerging adults, access to mental health services is critically important for early identification of mental health concerns and linkage to appropriate services. A focus on access was chosen to support children and families in their access to and navigation of mental health care services in Georgia. Short-term strategies to increase access to care include service mapping for behavioral health service utilization,

increasing behavioral health services in schools, and improving families' abilities to navigate the current system. Long-term strategies include recruiting practitioners in shortage areas, strategically increasing the use of telemedicine and telehealth services, and increasing continuity of care.

At the heart of the SOC approach are **coordination** and collaboration between child-serving agencies and organizations, and between the child, family and the larger system. Coordinated communication systems between local, county, regional, and state bodies are a vital feedback loop to ensure that local and regional needs and resources are understood, and state and county-level policy objectives are being achieved. This area of focus was chosen as an integral part of a coordinated network that serves children and families. Short-term strategies to increase coordination include increasing training on SOCs for stakeholders and building and maintaining feedback loops between local, regional, and state agencies and systems. Long-term strategies include creating and utilizing a common language as it relates to discussing SOC principles, and addressing gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; Intensive Care Coordination (IC3), and therapeutic foster homes.

The behavioral health **workforce** in the United States is inadequate to meet current and growing service demands and behavioral health needs. Workforce issues can be compounded by geographic regions and characteristics, with rural areas at even more risk of experiencing workforce shortages. As over half of Georgia counties are designated as rural, the IDT has identified workforce a major barrier to access to care for children and families. To develop, maintain, and support a culturally competent, trauma-informed workforce to meet the needs of children and youth, short-term strategies including targeted expansion of educational and financial incentives to address behavioral health workforce shortages and developing a clearinghouse of evidence-based educational materials that will be employed along with the long-term strategy of developing a state mental health workforce plan across agencies.

Cross-agency commitment to effective and efficient spending is necessary for a comprehensive, community-based, family-driven, youth-guided, culturally competent and trauma-informed SOC framework to operate in Georgia. The braiding and blending of interagency funds is a key way for multiple agencies to achieve more effective and efficient spending. In the short term, strategies to solidify interagency funding of the IDT as the oversight body for the SOC in Georgia and create and utilize SOC guiding principles for contract development will help to address this focus area. The long-term strategies to establish funding and **financing** for the SOC consist of reviewing financial mapping reports to find opportunities to braid or blend funding and the collaboration of IDT agencies in applying for and releasing funding opportunities and procurements when behavioral health is a key component.

Ongoing **evaluation** of Georgia's child-serving systems is critical to sustainability and success. To ensure that the proposed SOC is achieving its desired goals, the IDT will review evaluation tools to identify key metrics applicable to Georgia and provide these tools to the state, local, and regional teams as well as other child-serving systems to self-evaluate their SOC work. The long-term strategy for evaluation is for the IDT to institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and regularly reported to the BHCC.

In addition to work which is the focus of the IDT, the IDT membership follows and participates in legislative efforts focused on improving the system of care for youth with SED. IDT members or the agencies they represent are often asked to provide information to various study committees. In the past couple of years there have been four committees that had an interest in the target populations of the IDT:

- Children's Mental Health (House)
  Examined early intervention and prevention services; identifying available resources for children with mental health issues; and evaluating possible improvements in delivery of services.

- Health, Education & School Based Health Centers (House)
  http://www.house.ga.gov/Committees/en-US/School_Based_Health_Centers.aspx

- Preventing Youth Substance Use Disorders (Senate)
  http://www.legis.ga.gov/legislation/en-US/Display/20152016/SR/487

- Rate of Diagnosis for Children with Attention Deficit Hyperactivity Disorder (Senate)
  http://www.legis.ga.gov/legislation/en-US/Display/20152016/SR/594

During the Summer of 2017, the Governor appointed a new commission to focus on children and families, the Commission on Children's Mental Health. The Commission was charged with providing recommendations on improving state mental health services for children. The commission included health care experts, state leaders and children's advocates. The commission reviewed programs and areas identified, as well as the funding necessary to make improvements, and returned eight recommendations to the Governors. Seven of the eight received funding.

Local Interagency Planning Teams (LIPTS)

Local Interagency Planning Teams (LIPTS) have evolved through several years even since they were mandated into law. They are seen as existing collaborative bodies that have value as community stakeholders interested in youth with SED and their families. LIPTs are established at the county or multi-county level, depending on the size of the community, the number of children at risk, and the geographic availability of resources. The purpose is to improve and

facilitate the coordination of services for children with severe emotional disorders (SED) and/or addictive disease (AD). Goals are:

- To assure that children with SED and/or AD and their families have access to a system of care in their geographic area;
- To assure the provision of an array of community therapeutic and placement services;
- To decrease fragmentation and duplication of services and maximize the utilization of all available resources in providing needed services
- To facilitate effective referral and screening systems that will assure children have access to the services they need to lead productive lives
- Membership of the Local Interagency Planning Team (LIPT) includes representatives from each of the following: Division of Family and Children Services, Department of Juvenile Justice, mental health service providers, Rehabilitation Services, Education, Public Health, Family Connection Partnership, and Parents or parent advocates.

The LIPT network has remained strong and they are monitored by the DBHDD Regional Child and Adolescent (C&A) Specialists who attend meetings and serve as the agency's voice and anchor in the approximately 119 LIPTs throughout the state. Many of the LIPTs from the smaller districts have collaborated and meet jointly.

Regional Interagency Action Teams (RIATS)

Regional Interagency Action Teams (RIAT) created after the LIPTs were not required by law, and were intended to provide a feedback loop for collaborative learning regarding the operation of the LIPTs. Regional Teams were initially established in all 6 DBHDD regions. These teams met to identify shared and cross-cutting issues related to children's behavioral health as identified in the LIPT processes. Goals were:

- To assure that gaps in services are identified
- To assure that barriers at the local level are identified and addressed
- To assure a common vision at the regional level
- To decrease fragmentation and duplication across partners
- To identify strengths in processes

Membership of the RIAT included the chairpersons of the LIPTs located within the region, regional representation by mandated agencies, LIPT trainers, and family representatives. The teams were facilitated by the DBHDD Regional C&A Specialists. Information from these meetings was to be provided to the DBHDD Regional Services Administrator, the DBHDD Directors of Child and Adolescent Mental Health Services and Addictive Disease Services, and the IDT. The findings were to be used to improve processes and help inform the development of the State Plan for the Coordinated System of Care. Unfortunately, there was variability in the work of the RIATs and many of them did not functioned as intended. Most RIATs discontinued meeting. The purpose and vision for these teams is being revisited and reconsidered.

Recommendations have been made to the Interagency Directors Team regarding their recreation and sustainability.

The DBHDD Regional C&A Program Specialist positions were established to ensure that children receive appropriate mental health and substance abuse services. They serve as a consultant and resource in the regions across child serving agencies. These staff members are involved in various activities which support a system of integrated services. As related to LIPT and RIAT involvement the Program Specialists: facilitate and coordinate RIAT meetings where RIATs exist; coordinate multi-agency planning efforts with LIPTs; attend LIPT meetings and present cases as needed; conduct training and provide technical assistance; assist in the development of local interagency agreements; act as a liaison between LIPTs and DBHDD. The Program Specialists also work to ensure continuity of care across services and child-serving systems. They educate other child serving agencies and stakeholders on DBHDD policies, procedures, and practices; provide technical assistance to DFCS and DJJ to ensure a MH connection in the community; serve as bridge to connection to other services such as AD and DD; and identify growing regional trends related to continuity of care in inter- and intra- related service delivery systems.

Criterion IV: Targeted Services to Homeless and Rural Populations

Homeless

The Georgia Alliance to End Homelessness (GAEH) developed the Georgia Campaign to End Child Homelessness. According to a plan developed out of this effort, there are over 45,000 children who experience homelessness in Georgia each year. In addition, according to the Georgia Department of Community Affairs 2015 Report on Homelessness, during the Point in Time Count in January 2015, at least 13,790 people were literally homeless in Georgia which is a 19% decrease from 2013. Children under the age of 18 comprise 18% of the homeless population and 13% of the homeless population are youth between the ages of 18 and 24. As relates to family composition, 30% of the total homeless population are in families with children.

The 2014 America's Youngest Outcasts: A Report Card on Child Homelessness published by the National Center on Family Homelessness at American Institutes for Research provides state rankings based on four domains: extent of child homelessness (adjusted for state population); child well-being; risk for child homelessness; and, state policy and planning efforts. Georgia ranks 40th out of 50 on the composite score. For each domain, the ranking was as follows: 28th for extent of child homelessness; 43rd for child-well-being; 49th for risk for child homelessness; and, 24th in state policy and planning. As relates to extent of child homelessness, in 2010-2011 there were 63,818 homeless youth and in 2012-2013 it had increased to 73,953 youth. Georgia continues to struggle with child poverty and continues to lag in economic well-being. These factors have a tremendous impact on child homelessness in this state.

DBHDD collects data on living status of youth with SED enrolled in services. Providers are required to gather information on living situation upon enrollment in services. Providers under contract or agreement with DBHDD provide early intervention and mental health treatment services to identified youth with SED and their families who are at risk for homelessness or homeless and ensure that appropriate interventions are provided to meet the needs of this high-risk target population in Georgia. The Core Customer definition for eligibility for services identifies priority groups for state funded services. Youth who are homeless and who are at risk of homelessness are included in the priority group targeted for state funded services. Comprehensive mental health services are available in all regions for children and adolescents with SED who are homeless. The total unduplicated Child and Adolescent DBHDD MH consumers authorized services during FY16 where their living situation was identified as either "Homeless - Shelter" was 97.

Youth with SED may have runaway behaviors, families with economic pressures and poverty, poor familial relationships, substance abuse and/or family substance abuse, violence, physical, sexual and emotional abuse and neglect within the family. Some youth with SED also have the "throw away" experience in which parents or caretakers tell them to leave the home or do not receive support when the youth are placed outside the home and parents are reluctant to have them return to their homes. These risk factors can increase the chances for homelessness for the family and/or the youth with SED. Youth who are in state custody through the child welfare system often do not have safe family members who are involved with them and they oftentimes end up in emergency shelters, child protective custody or foster care. Many of these youth grow up in the child welfare system and age out at the age of eighteen only to sign themselves back into care for access to Independent Living Programs, funded through DFCS.

Youth who are aging out of residential services or PRTFs are often the more complex youth to plan for services and supports appropriate to meet their needs. This group of youth with SED often drops out of services, become homeless and/or become involved with the criminal justice system. With the High-Fidelity Wraparound Program, youth served in or at risk of PRTFs up to age 21 can be offered the option of home and community-based services. Youth who are homeless or at risk of homelessness are a priority population to be served by DBHDD providers.

DBHDD has participated in collaboratives focused on homelessness. Since FY19 the Supported Housing Unit Director has been DBHDD's primary contact. In addition to past involvement with coalitions in Georgia to address homelessness, she is a current member of the NASMHPD Housing Task Force. In the past the Assistant Director of Adult Mental Health participated in the United States Interagency Council on Homelessness (USICH) Criteria and Benchmarks for Ending Family Homelessness: Stakeholder Input Session #3 (June 8, 2017). This session was designed to allow stakeholders to provide input on the proposed benchmarks and the questions to

assess a community's progress in achieving the goal of ending family homelessness. This input will be used to help identify where further refinements are needed. The Supported Housing Unit Director is also responsible for implementation of the Projects for Assistance in Transition from Homelessness (PATH) Program. One of the state's ten PATH Teams, the Community Advanced Practice Nurses (CAPN), provides outreach and adult mental health assessment services at two women & children's shelters: Atlanta Day Shelter for Women & Children and Atlanta Children's Shelter.

In FY19 the OCYF contracted with the Georgia Parent Support Network to begin outreach services for homeless youth.

The DBHDD Regional Field Offices and their providers also participate in and support local efforts related to improving service delivery to homeless women and children. The Region 2 Field Office staff coordinate with child welfare regarding homeless children and assist in identifying resources for their parents. APEX, DBHDD's school-based mental health program also provides counselors who can link families to housing resources as needed. In Macon, Georgia, Apex is co-located with First Choice Primary Care (FQHC) in an elementary school. In Athens, Georgia, Advantage Behavioral Health Services has led the development of the Athens Resource Center for Hope which includes formal partnerships among Advantage Behavioral Health Systems, Athens Nurses Clinic, Live Forward (Formerly AIDS Athens), Athens Area Homeless Shelter, and Little Angels Daycare. Specifically, Advantage provides outreach and support services within a co-located facility that also houses the Athens Nurses Clinic and Live Forward. Through this partnership they are able to provide collaborative case management and support services that meet the health, financial, and overall stability needs of local homeless individuals and families. In Region 3, the Field Office provides assistance to women's shelters and domestic violence shelters who are needing help with locating housing and behavioral health providers. If the person referred meets criteria, they are linked with one of the state funded providers to complete the GHVP. The PATH teams have also placed women with children into the GHVP. In Region 5, Gateway CSB works with the local Homeless Coalitions in their service area. One of the Homeless Coalitions is chaired by the director of a children's shelter. This coalition has a particular interest in the needs of children with SED who are homeless. In another service area of the region, the provider, Pineland CSB, uses its Shelter Plus Care program to support the needs of women and children. Currently they have 3 households with women and their children in their Shelter Plus Care Services.

Rural Services

Rural is defined as those counties not included in Metropolitan Statistical Areas (MSA). Five of the six DBHDD regions have rural areas. As such, service to persons living in rural localities is of primary concern. Mental health service planning for rural areas occurs at a local level through the six DBHDD Field Offices. Field Offices, through input from their Regional Advisory

Councils, public forums, public surveys, focus groups, and youth and family satisfaction surveys gather information to better plan for services in all areas of the state, particularly rural areas.

DBHDD contracts with providers to cover all areas of the state. There are twenty-four CSBs, as well as additional comprehensive service providers, and specialty providers. GCAL provides people seeking behavioral health services with information and access to comprehensive outpatient and crisis services throughout the state.

There is a significant behavioral health professional workforce shortage in Georgia, creating challenges to provide all services in all areas. In many counties, there are few to no licensed behavioral health practitioners, and DBHDD is often in competition with the educational, juvenile justice, and child welfare organizations for these critical staff. In addition, transportation is a problem for consumers in some areas. Medicaid consumers utilize Medicaid transportation systems to get to services; however, transportation services have not been readily available to all persons.

Increasing access to services has been a major thrust of the DBHDD and its Regional Offices. Providers are required to deliver services out of the clinic setting. Although services for children and adolescents have been able to be delivered outside of the clinic since the early nineties, implementation of the Medicaid Rehabilitation Option has allowed for a broader array of service options to be delivered in homes and other locations. Providers are required to have extended service hours on weekdays and weekends as well. Some providers also send staff to juvenile courts, child welfare offices and schools to make services more accessible to youth and their families. In addition, there is a higher level of reimbursement for providers delivering services outside of a clinic site, where the person lives or goes to school.

Two of the services implemented in the Rehabilitation Option are Intensive Family Intervention (IFI), and Community Support (CS). These services can be delivered in any setting and as a result are delivered in closer proximity to the youth and based on the individual needs of the youth and their families. The traditional model of (IFI), with a strong team identity for services, is tested heavily in rural areas in which staff travel long distances to see consumers. A healthcare professional shortage in rural areas of the state also affects the ability to develop service capacity for IFI due to the need for a higher level of professional and credentialed staff. Less intensive levels of mobile service like CS have proven to be easier to implement in rural settings. The challenge is to implement these model approaches to service in cost efficient ways and promote access to services for all consumers in need. Mobile crisis is also available statewide.

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One of the initiatives put forward by DBHDD to expand services throughout the state, including rural areas, is a school-based mental health project. This effort mentioned previously is referred to as Georgia Apex. DBHDD provides grant funding to 24 Community Service Boards and three

additional providers to support the integration of community mental health professionals in the learning environment of targeted schools. Focusing on disparate populations, as well as local schools with identified need around school climate, the overarching goal is to increase access to mental health services and to ensure increased and sustained coordination between community mental health providers and local education agencies.

DBHDD has been working with the state's Department of Community Health to promote the use of telemedicine as an access tool for rural areas. Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care.

Georgia maintains and is growing the following approaches to telemedicine:

- The state continues to use teleconferencing for clinical supervision and discharge planning purposes in its state facilities;
- Teleconferencing can be utilized for the provision of Community Transition Planning, a transition support services which provides support services to individuals in the last few days of a facility admission, promoting post-inpatient community engagement;
- Georgia's Medicaid State Plan continues multiple service definitions which allow telemedicine (traditional services such as Physician Assessment, Diagnostic Assessment). In 2017, telemedicine capacity was expanded to allow non-English speaking individuals to access a same-language speaking practitioner via telemedicine for any Core and most Specialty services.
- There are over 60 DBHDD provider sites that are participating in the Global Partnership for TeleHealth [http://www.gatelehealth.org/about/partnerslocations/]. All state hospitals are telemedicine enabled.
- Both of the DBHDD's Mobile Crisis vendors has telemedicine capacity.
- Approximately a dozen more private and non-profit affiliated vendors are telemedicine enabled

  DBHDD provided telemedicine capacity grants to XX # of youth mental health providers for youth behavioral health services and 12 Community Service Boards specific to ASD services expansion.

DBHDD continues its telemedicine interactions to promote quality stabilization, treatment, and transition. The DBHDD policy focuses on three key interaction areas:

- Telemedicine between DBHDD facilities and/or offices
- Telemedicine between DBHDD facilities and other medical facilities, for example:
  - ✓ Consultation with Emergency Departments or Crisis Stabilization Programs regarding referral for admission
  - ✓ Medical care consultation from specialists
- Telemedicine between DBHDD facilities and community entities, for example:

- ✓ Discharge planning with Community Providers of behavioral health or developmental disabilities services
- ✓ Sheriff Departments
- ✓ Civil commitment hearings

Lastly, LIPTs, our local system of care infrastructure covers all 159 counties. They have had a major impact on interagency collaboration and resource development for youth in rural communities. The natural supports as well as more formal systems have a forum for working together to develop specific community plans for youth with SED who might otherwise need to leave their communities for adequate services.

Criterion V: Management of Human and Fiscal Resources

Financial Resources

Since the late eighties, the funding level for community-based child and adolescent mental health services has increased. This increase has come because of new state appropriations, redirection of existing funding from closure of hospital beds, and federal funds. Over $60 million dollars is available to fund child and adolescent mental health services. Funding has supported an expansion of services including traditional outpatient services, community support, school-based mental health services, intensive family intervention services, mental health clubhouses, mobile crisis and crisis stabilization units. Historically, the majority of state and federal mental health block grant funds were allocated via contracts primarily to public providers of mental health services for the range of community-based mental health services. With the change to an FFS model for children and adolescents, DBHDD primarily has provider agreements for services and fewer contracts with grant in aid allocations.

For SFY20, there is $6,683,546 of MHBG funds available to support child and adolescent mental health services and administration. The majority of funding, $6,232,985 provided for child and adolescent services is contracted and supports the delivery of Care Management Entity Services (CME), Mental Health Clubhouses, a transitional age youth and young adult peer center, and first episode psychosis programs. The remaining amount of $450,561 is used to support training of providers and to support further development of family support/network organizations.

The Medicaid Rehabilitation Option, implemented in FY2002, enabled the state to offer an expanded array of services in settings other than mental health centers, greatly enhancing the scope and focus of the service system. With this shift, the DBHDD also received the Medicaid "State Match" dollars in its budget, and became "at-risk" for managing the utilization of Medicaid mental health services. With the initial change to Medicaid managed care, over $20 million dollars was removed from the DBHDD budget to provide for state match for the Care Management Organizations (CMOs). With the additional change to a foster care CMO, DBHDD

transferred $24 million of the state child and adolescent mental health budget to DCH to fund the services to foster care and juvenile justice youth. As previously mentioned, DBHDD does not have responsibility for provision of mental health services to foster children. All physical and mental health services are the responsibility of DCH and the foster care/juvenile justice CMO. The state funds remaining support services to youth who are uninsured, disabled and receiving adoption assistance.

Human Resources

DBHDD recognizes the critical importance of staff development and training in supporting the delivery of quality services. DBHDD developed a Standard Training Requirement that was submitted to and approved by the Department of Community Health (DCH), the state's Medicaid agency, as part of the revision of Georgia's state plan for Medicaid Rehabilitation Option services. DBHDD utilizes a training curriculum, Relias Learning (online learning), as a training tool for preparing paraprofessionals to work in the field of mental health; all paraprofessionals are required to complete a list of required courses shortly after hire. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide either state-funded or Medicaid-reimbursable services in Georgia. This training curriculum includes courses such as Coordinating Primary Care for Needs of Clients; Mental Health Issues in Older Adult Populations; Cultural Issues in Mental Health Treatment for Paraprofessionals; Bipolar Disorder in Children and Adolescents, Overview of Family Psycho Education – Evidence based Practices, Alcohol and the Family for Paraprofessionals, Co-Occurring Disorders; and an Overview for Paraprofessionals, Suicide Prevention, and Suicide the Forever Decision.

In addition, key trainings on basic topics such as documentation and incident investigation are routinely offered for DBHDD providers. The **Office of Human Resources/Learning** has created DBHDD University and has implemented a Learning Management System (LMS) that provide online educational opportunities for both DBHDD staff and community providers. The LMS provides for course registration, record of course completions, assessment grades, transcripts, and printable course certificates.

The **Office of Human Resources/Learning** facilitates many other training and development activities that are offered through DBHDD. Providers and system of care partners have received training in Trauma Informed Care, Transitions to Independence Process, Dialectical Behavior Therapy, Trauma-focused CBT, Crisis Planning and Safety Planning, Adolescent Co-Occurring Mental Health and Substance Use Disorders, Suicide Prevention of at-risk populations, Mental Health Training for Spoken Language Interpreters and Training for Mental Health Clinicians in Use of Spoken Language Interpreter Services, Cultural Competence and System of Care Leadership and Approaches.

DBHDD funds and sponsors an Annual Georgia System of Care Academy with the most recent one, the 12th System of Care Academy, held in June 2019. The Annual System of Care Academy provides a shared value, principles, and practice focused conference. It is held each summer and key staff from DBHDD, Community Mental Health, Addictive Diseases, DFCS, GA DOE, DJJ, GVRA, DPH, DECAL, DCH programs, other professionals, families and youth from across the state are invited.

In addition, there was a separate youth track where youth were provided sessions on leadership, career development, building advocacy skills, esteem building, suicide prevention education, and domestic violence education, and others. There were over 400 attendees with over 100 families and youth.

Community Mental Health Services Provider symposiums are held to present shared values, philosophies, expectations, and training related to the service system guidelines and policies. These symposiums, known as provider technical assistance and training days are held once a year. All providers are required to attend. In October 2017, DBHDD will host the Community Mental Health Training and Technical Assistance Symposium. The Symposium is organized according to a clinical track and a leadership track. There will be sessions related to all providers, both adult and child and adolescent such as Accountable Care Service Delivery System Solutions, Recovery, Beyond Trauma, Treating Co-Occurring Disorders, Suicide Prevention, Treatment for Young People with 1st Episode Psychosis, Motivational Interviewing, and Crisis Management Strategies. There will be specific sessions held of interest to child and adolescent providers: Transition Age Youth Services and Support, Child and Adolescent Medications, LBGTQ, and Military Culture and Families.

In addition to a focus on clinical training, Office of Children, Family, and Young Adults implemented an *Occupational Stress Management* module for Crisis Stabilization Unit (CSU) providers and Psychiatric Residential Treatment Faculties (PRTF). This training module focuses on the occupational wellness of our residential and high-level treatment workforce. This module was piloted beginning in mid-2016 with training of Secondary Traumatic Stress (STS) training using both Train-the-Trainer and onsite training modalities to train all direct care staff in CSUs and PRTF. During the first year (2017), PRTF and CSU executive leadership and training personnel receive quarterly resources and job aids from DBHDD surrounding STS, self-care, and wellness to distribute to their direct care staff.

DBHDD partnered with the University of Georgia School of Social Work (SSW) to assess the professional development needs of the workforce. The assessment was divided into two phases utilizing a mixed methods approach (both quantitative and qualitative methodologies). One phase consisted of an online survey administered to direct care staff and supervisors at DBHDD facilities and agencies (n= 596 respondents). A second phase consisted of focus groups with

representatives of supervisors and direct care staff from the various treatment facilities and agencies under the auspices of DBHDD (40 participants). The objective of the assessment was to gain a comprehensive assessment of the behavioral health workforce specifically the Office of Children, Young Adults, and Families to guide the development of a data driven workforce development plan and initiatives.

The findings are currently being used to drive our workforce development initiatives and opportunities. These initiatives will include utilizing more technology such as asynchronous learning platforms to increase access to training and development especially for our hospital and residential facility workforce. Also, significant findings will be used to drive training and development content for our Annual Georgia System of Care Academy and Community Mental Health Training and Technical Assistance Symposium as well as other training and development events.

In addition, utilizing the availability of grant funds, DBHDD has been able to support providers, families and youth to attend national system of care conferences such as the National Federation of Families for Children's Mental Health Conference, the University of South Florida Research and Training Conference, the Alternatives 2017 conference, a SAMHSA small group meeting on Wraparound Innovations and a SAMHSA small group meeting on Medicaid Managed Care.

With funding from a CHIPRA grant Georgia developed a training and certification process for parents of youth with behavioral health conditions. Individuals who complete this course and certification work as Certified Peer Specialists for Parents (CPS-P) in Georgia's continuum of care for children, youth and families. A curriculum has also been developed to certify peer specialists to work with youth (CPS-Y). The Family Liaison in the Office of Recovery Transformation has led the development of the Certified Peer Specialist –Parent curriculum as well the Certified Peer Specialist-Youth curriculum. To assist with the latter, a young adult was hired to work on curriculum with other youth leaders to ensure and facilitate youth voice in the design of the curriculum. Over 100 parents and 30 youth have been trained and certified.

Emergency Service Provider Training

All services in the Georgia DBHDD system are provided under contract or agreement with private or public providers of behavioral health services. Local providers work with emergency personnel such as Sheriff's Departments, Hospital Emergency Rooms and county jails on issues related to consumers with behavioral health needs. The local providers educate these responders on the needs of consumers as well as on the services available through their agencies. In particular, in areas that are more rural, provider staff develops relationships with local hospital emergency rooms and other responders to keep them apprised of the unique needs of persons with mental illness and serious emotional disturbance in emergency situations. In the more

metropolitan regions, the providers sometimes contract with outside vendors to do training of emergency personnel.

Behavioral Health Link provides information and marketing materials regarding the Georgia Crisis and Access Line to hospital emergency room personnel and local law enforcement staff. The intent is for all emergency services personnel to be informed of the availability and process for accessing 24/7 crisis response for any individuals in a crisis related to mental illness or addictive diseases.

In September of 2016, Governor Nathan Deal announced a law enforcement reform package that includes a multi-phase overhaul of officer training and certification courses. The reform package includes enhanced resources for Georgia Crisis Intervention Team (CIT) and a provision that will involve the transfer of CIT to the Georgia Public Safety Training Center (GPSTC), thereby streamlining training requirements and increasing access to more than 57,000 state and local officers. DBHDD now blends funds with GPSTC, to provide CIT training to Georgia's law enforcement officers using a curriculum that blends best evidence based practices from the new Bureau of Justice Assistance (BJA) CIT Model, the Memphis, Tennessee CIT model, and data gained from CIT practice in the field since 2006 In an effort to reduce the stigma associated with mental illness, the Georgia CIT Program's vision is a Georgia where citizens with serious mental illness receive medical treatment in lieu of incarceration. Georgia adopted a top-down approach to training law enforcement by forming a collaborative with executives from key departments of state government, mental health providers and advocacy organizations.

From FY06 through FY17, the CIT (Crisis Intervention Team) Program collaboration between NAMI Georgia and DBHDD trained police officers across the state to divert consumers from incarceration and link them to treatment services. In FY 17, 55 CIT trainings were conducted reaching more than 1,000 law enforcement officers. In addition, in FY17, DBHDD's OCYF, entered a separate contract with NAMI Georgia, to provide CIT for Youth Training. In general, CIT for Youth programs train officers on adolescent brain development and how mental health symptoms manifest with youth. Children and youth express their distress differently than adults and often respond to different styles of interaction. In addition, the training helps officers and school staff work to better address mental health concerns in a school setting. CIT for Youth programs teach law enforcement officers to connect youth with mental health needs to effective services and supports in their community. The goal is to intervene early in emerging mental health issues and prevent youth from becoming involved in the juvenile justice system. The programs work with schools, school-based police officers, children's mental health providers and parents to accomplish these goals.

During 2017, NAMI held several stakeholder meetings with over 175 stakeholders in Region 3 (Albany State University), Region 4 (Albany), and Region 5 (Savannah & Vidalia) to identify the barriers schools have connecting their students and resources available for them. Over 100

participants were trained on the CIT-Y, which included Atlanta Public Schools Police Department and Albany Police Department as well as a Train the Trainer training to the Atlanta Public School Department of Education.

In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, NAMI facilitated a new DBHDD-funded Introduction to Behavioral Health Crisis curriculum--seven (7) 16-hour courses for Law Enforcement Officers waiting to attend the 40-hour CIT class, and eight (8) 8-hour courses for First Responders and 911 Operators— The goal and objective of the new **training** is to provide an in-service introductory course on behavioral health crisis for law enforcement officers as a precursor to the Georgia CIT Program. Components of the new class include:

1. An introduction to signs and symptoms of the behavioral health disorders law enforcement officers are most likely to see during their day-to-day encounters with citizens experiencing behavioral health crisis, disorders such as Depression, Bipolar Disorder, Post Traumatic Stress, Schizophrenia and Autism.
2. Statistics on the prevalence of mental illness, including information on incarceration rates, suicide, homelessness, recovery success rates, and the impact of stigma.
3. A basic overview on Legal Issues highlighting some of the Official Codes of Georgia relative to 1013, Probate Orders (OTA), transports, immunity, HIPPA, case law citing deliberate indifference, and Georgia Accountability Courts.
4. Community resources including information on the Department of Behavioral Health and Developmental Disabilities (DBHDD), Behavioral Health Link (BHL), Community Service Boards (CSBs), Advocacy and Recovery organizations such as National Alliance on Mental Illness (NAMI), Georgia Mental Health Consumer Network (GMHCN), Georgia Parent Support Network (GPSN), and the Georgia Council on Substance Abuse
5. Consumer Perspective featuring an "In Our Own Voice" presentation by a person living in recovery with mental illness. The presenter shares dark days of mental illness, acceptance, treatment, success hopes and dreams.
6. The last module will be an introduction to CIT, citing the history of CIT, benefits of CIT training, successful CIT outcomes, and skills taught during the course.

The state's Crisis Intervention Team Training Manual states that one of the main collaborative objectives between the GBI and NAMI is to "Ensure that people with mental illnesses and other brain disorders always receive treatment, in lieu of incarceration in most cases."

The Georgia Bureau of Investigation (GBI) has incorporated a module on trauma into its monthly training for new Crisis Intervention Team (CIT) State Patrol officers across the state. The training includes interviews with actual consumers who have received services for PTSD, education on the signs and symptoms of trauma and other mental illnesses, as well as de-escalation techniques for use in working with persons in crisis related to trauma. A goal of the CIT training program is that officers understand that involvement in many infractions of the law

may be a result of a person's trauma history or failure to receive proper trauma-informed treatment, rather than a result of intentional wrongdoing.

The FY18 transition of CIT to GPSTC will allow for expansion of CIT training to at least double the number of officers reached in previous years, and will allow for development of "CIT University". New online training modules will be developed to provide advanced add-on training for CIT certified officers. Modules may include trauma, similar to the current GBI module, Alzheimers and Dementia, veterans, youth in crisis, autism, and other topics designed to increase officers' knowledge and improve responses in the field.

DBHDD's Assistant Director of Adult Mental Health Services is the Program Manager for the GPSTC contract and is a member of the GPSTC Crisis Intervention Team Training Advisory Board.

Disaster Preparedness

DBHDD has a Disaster Mental Health Coordinator's (DMHC) position which is fully funded by the Georgia Department of Public Health. DBHDD's DMHC works with the Georgia Emergency Management Agency and other emergency preparedness agencies to ensure that the behavioral health needs of Georgia residents are included in state-level plans by participating in numerous workgroups and task forces. The DBHDD Regional Hospitals and provider agencies are members of Regional Emergency Preparedness Healthcare Coalitions throughout the state and they participate in exercises with local healthcare and emergency preparedness partners. ACT, CST, ICM, CM, and SE providers receive training in continuity of operations and personal disaster planning as well as training on how to work with individuals to develop a personal disaster plan. Georgia's disaster mental health website at www.georgiadisaster.info contains information and resources on disaster mental health planning. Training in disaster preparedness is available for providers. DBHDD has a continuity of operations plan policy for its state office and policy that requires continuity of operations for all contracted providers. Disaster mental health training and exercises takes place throughout the state several times a year.

Staffing Issues

Community mental health services in Georgia are provided through a number of contracted public and private provider agencies. These are not state agencies and therefore we do not have specific knowledge about the numbers of staff of differing professional disciplines that are employed by each agency. Staffing requirements for services within the Georgia mental health system are established in both the *Provider Manual for DBHDD Community Mental Health Providers* and the Medicaid Services Manual.

Practitioners are divided into professional and paraprofessional categories, and licensed mental health professionals practice under the scope of relevant practice laws. Paraprofessionals are

those practitioners who are not licensed or certified to practice independently. All paraprofessionals as aforementioned must complete standardized training. Each service definition contains specific staffing patterns that include the required level of supervision by a licensed practitioner, as well as staff to consumer ratios that meet standards of care. Urban areas of the state generally have more access to all categories of professional staff. Recruiting and retaining qualified staff presents a continuous challenge to rural providers. There is a shortage of Child Psychiatrists and psychiatric nurses in Georgia. Nurses and social workers are also under-represented within the public mental health system, causing providers to focus significant resources on recruitment and retention activities. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are made to secure qualified staff for services provision.

According to the Georgia Composite Board there are 6,800 Professional Counselors; 872 Marriage and Family Therapists; 3,878 licensed Clinical Social Workers; 2, 732 licensed master's level Social Workers; 114 Associate Marriage and Family Therapists; 1,454 Associate Professional Counselors; and 2,382 Licensed Psychologists. Many rural counties report lack of child and adolescent psychiatry services. In addition, in looking at recent graduates in 2017 from the University System of Georgia, there were 354 graduates in Social Work; 40 graduates in Marriage and family Therapy; 12 graduates in Psychiatric Nursing; 3237 graduates in School Counseling; and 9 graduates in Clinical Psychology.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

UNMET SERVICE NEEDS AND PLANS

Georgia is the 24th largest geographic state and the eighth most populous state in the Nation. Georgia is a microcosm of the nation culturally, racially, and ethnically. Its diversity includes mountainous regions, rural farming communities, heavily populated urban centers, and a coastal region with a significant senior population. With 159 counties, Georgia's land mass is over 57,000 square miles with 168 persons living per square mile. The distance from the Northern part of the state, the mountainous region, to the southern part of the state, the coastal plain, is 300 miles. And as the eighth most populous state, Georgia's population has grown 8.6% from 2010 to 2018, increasing from 9,688,681 to 10,519,475. At its current growth rate, Georgia's population will exceed 14 million in the next 20 years.

Four counties, all located in the core counties of metro Atlanta, account for almost 3.5 million (33%) of the state's 10.5 million population. Of the remaining 155 counties, 26 counties are in the 300,000 to 100,000 population range, 32 are in the 99,000 to 30,000 range, and 97 have populations of less than 30,000 (including 33 counties with populations of less than 10,000).

According to the 2018 U.S. Census estimates, of the state's 10.5 million residents, 60.52% were white, 32.4% African American or black, 4.3% Asian, .5% American Indian or Alaska Native, 2.2% two or more races, and 9.8% were Hispanic/ Latino. Foreign born persons represent 10.0% of the population and 13.9% of the state's residents speak a language other than English at home.

With respect to age, Georgia's population continues to be younger compared to the U.S. as a whole, ranking 4th in the percentage with the largest population under 18 years old. Persons under 5 years of age represent 6.2% of the population, children and youth under 18 years 23.8%, persons ages 18 to 64 62.3%, and persons age 65 and above 13.9%. Females represent 51.4% of the state's population. Sexual orientation data is not available for Georgia.

For education and income, U.S. Census data indicate that 86.3% of persons age 25 and older (2013-2017) are high school graduates and 29.9% have a bachelor's degree or higher. Georgia's 2013-2017 median household income was below the national average at $52,977 compared to $57,662 nationally. The percentage of people below the federal poverty level (2013-2017) is higher than the U.S., 14.9% versus 12.3%. Georgia's unemployment rate has improved significantly over the last four years, decreasing from 7.3% in July 2015 to 3.7% in July 2019. Although in years past, the state's rate was higher than the U.S. as a whole, Georgia's rate is currently the same as that of the whole nation.

Georgia uses the federally-run health insurance exchange. During the open enrollment period for 2019 coverage, enrollment in private plans through the Georgia exchange totaled over 460,000, representing about a 20,000 decrease in enrollment from the previous year.

A significant number of Georgians remain uninsured because they are not eligible for the state's federally run exchange or are ineligible for Medicaid. Georgia has chosen not to expand Medicaid. The Georgia Department of Community Health (DCH), designated as the state agency for Medicaid and PeachCare for Kids®, provided access to health care for nearly 2 million low income children, pregnant women, and people who are aging, blind and disabled. Under current

eligibility requirements single childless adults do not have access to Medicaid benefits. DCH also administered the State Health Benefit Plan (SHBP), providing health care coverage for 661,165 state employees, public school personnel, retirees and dependents as of June 2018. Combined, these two divisions provided health insurance coverage to approximately one in four people in the state, or more than 2.6 million Georgians.

Access to care for Georgians with behavioral health issues is impacted by the large number of rural counties in the state and the lack of transportation outside of metro areas. Nearly half of the state's residents live in rural areas. These areas have no public transportation and individuals without access to a car have difficulties accessing care, including behavioral health care.

A unifying condition for virtually all of Georgia's homeless population is poverty. Many people who are homeless also experience some type of personal vulnerability that places them at risk, such as: family violence, physical disability or chronic medical problems, mental illness, substance abuse, and developmental disability or brain injury. (DCA 2015 Report on Homelessness)

A Department of Community Affairs Balance of State Continuum of Care (BoS CoC) Point in Time survey conducted in January 2017, which covered 152 of Georgia's 159 counties, determined that 3,176 people were literally homeless. This represents a 36% decrease from 2015. Of those 3,176 persons, 1,843 were unsheltered and 1,873 were sheltered.

Fifty-five percent of the total homeless population in the 2017 BoS CoC survey is male; however, that percentage does differ when it is broken down by homeless status. Men are more commonly experiencing unsheltered homelessness. This could be skewed due to the fact that there are more shelters in the BoS that serve predominantly female victims of domestic violence, than there are shelters that serve men specifically.

The majority of the CoC's homeless population identifies as Black or African American. Six percent identify as Hispanic or Latino. Children under the age of 18 comprise 23% of the homeless population, and 8% are between the ages of 18 and 24.

People with special needs are the most vulnerable subset of the homeless population. According to the data collected for the 2017 Point in Time survey count, 6.5% of people experiencing homelessness are chronically homeless, meaning that they have a disability and have been homeless for at least one year, or four times in the past three years. Four percent of the homeless population observed in January of 2017 were veterans. Almost 12% (373) were persons with had mental health issues and about 16% (496) were individuals with substance use disorders.

Data from a count conducted in January 2017 by all nine of Georgia's homeless program regions (Continua of Care) and that covers all 159 counties showed that on the day of the survey at least 10,373 people were literally homeless in the state. This count represents a 25% decrease from 2015.

There are several homeless subpopulations that HUD is tasking CoCs with prioritizing, two of which are veterans and chronically homeless. Seven percent (7%) of the homeless population in

Georgia on the night of the count were veterans. Ten percent (10%) of the homeless population was experiencing chronic homelessness on the night of the count. Chronic homelessness is defined as someone experiencing continuous homelessness for at least one year or at least four times in the past three years with their total time in shelters or on the street adding up to over one year and who has a disabling condition.

Source: Georgia Department of Community Affairs 2017 Report on Homelessness; Georgia Department of Community Affairs Georgia's 10,000 2017 Report on Homelessness.

Military Veterans

Georgia has a ten military bases and installations and it is estimated that Georgia has over 100,000 military and National Guard personnel. (About.com US Military Major Bases and Installations). In addition, Georgia has a large number of veterans living in the state. According to US Census data, Georgia has over 690,000 veterans. Many veterans are able to leave the military service and re-integrate into the community without significant problems. They are able to find work, start or continue their education, and reunite with their families. National and regional research indicates, however, that in the post 9/11 era there are increasing number of veterans who have difficulties after leaving military service, particularly those who served in combat and/or had multiple tours of duty in Iraq or Afghanistan with short time between redeployments.

Veterans face a number of re-integration challenges, including the behavioral adaptations that may be required in moving from a highly structured life in the military to civilian life. Those who served in combat conditions particularly may face difficult transitions, ranging from losing the strong bonds developed with their colleagues to post traumatic stress disorder (PTSD) to mental and/or physical health disabilities. They may also have difficulties in re-establishing family ties that can provide them with support. "When soldiers are not well reintegrated into society, they can face severe challenges. Some of the most crippling of those challenges are unemployment, mental and physical disabilities, and homelessness." (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012) Further, data has shown that veterans are at increased risk of suicide. Although data is limited, according to the US Department of Veterans Affairs, in 2016 in Georgia there were 202 suicides with a rate of 28.9 among veterans compared to 1,352 suicides among the general population and a rate of 17.4.

The families of military and veteran personnel also face challenges. The stress of military life including deployment (of the military veteran alone as well as family moves to new military assignments) can impact family members as well. Reintegration of the military member (particularly those with trauma related issues) into the family after deployment can also affect other family members.

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Community

Data on the number of LGBTQ individuals nationally as well as in Georgia is very limited. The Williams Institute estimates that less 10% (estimates vary) of adults in the U.S. identify as lesbian, gay or bisexual and that approximately 0.3% of adults are transgender. Members of the LGBTQ community often face a number of challenges including homophobia, stigma, discrimination, family and community acceptance, and health disparities (including mental

health and drug use).

Although data is limited, statistics regarding LGBTQ youth are particularly of concern. A CDC study has shown that LGBTQ youth represent 20-40% of homeless youth, 19% of child welfare youth, and 20% of juvenile justice system youth. In addition, they are three times as likely to be bullied at school, three times as likely not to go to school because of not feeling safe, and three times as likely to be sexually assaulted. LGBT youth are four times more likely to attempt suicide than straight peers and questioning youth are three times more likely. In addition, "suicide attempts by LGBT and questioning youth are four to six times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers". It is also alarming that almost half of transgender youth have "seriously thought about taking their lives, and one quarter report having made a suicide attempt". Research has also shown that LGB youth who "come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection". It has been shown that each episode of LGBT victimization (i.e., physical or verbal harassment or abuse) increases the chances of self-harming by 2.5 times on average. (The Trevor Project)

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), the Single State Authority for Mental Health, provides behavioral health services for low income uninsured and underinsured Georgians.

ADULT MENTAL HEALTH-UNMET NEED

According to the Behavioral Health Barometer, Georgia 2015 there has been an increase in the percent of SMI among adults from 3.7% in 2012 to 4% in 2015. The annual average percentage in 2014-2015 (4%) was similar to the corresponding national annual average percentage (4.1%). In addition, the percentage of mental health treatment among adults with any mental illness indicated that 37.4% received treatment and 62.6% did not receive treatment in 2014-2015. Out of the adults who received treatment 73,5% reported improved functioning compared to 71.8% in the nation as a whole.

In the Mental Health America Report, *The State of Mental Health in America 2019*, Georgia is ranked 21st overall in terms of prevalence of mental illness and compared to other states based on the 15 measures of which 7 are related to adult mental health. These seven measures and their rankings are:

1. Adults with Any Mental Illness-17th (2017 – 22nd)
2. Adults with Dependence or Abuse of Illicit Drugs or Alcohol- 4th (2017 - 12th)
3. Adults with Serious Thoughts of Suicide- 18th (2017 - 22nd)
4. Adults with AMI who Did Not Receive Treatment-42nd (2017 - 46th)
5. Adults with AMI Reporting Unmet Need- 27th (2017 - 18th)
6. Adults with AMI who are Uninsured-47th (2017 - 46th)
7. Adults with Disability Who Could Not See a Doctor Due to Costs-46th (2017 - 51st)

The overall ranking of Georgia on all seven adult measures was 31st, up from 40th in 2017

Data in the Georgia 2018 Uniform Reporting System (URS) tables indicate that 5.5% of those served received supported housing services; 2.9% received supported employment services; and, 3.2% received assertive community treatment services. Additional data indicated that among adults served in Georgia's public mental health system in FY18, 52.9 were not in the labor force. Also, 72.7% of adults reported improved functioning from treatment received in the public mental health system compared to 76.6% on average in the U.S and 70.6% median score.

Georgia's plans for system capacity and service development to meet adult mental health needs in the community are based on federal estimates of prevalence of serious mental illness in the population aged 18 and older. Prevalence tables are constructed annually for each DBHDD region based on county population figures for each county in the region. Georgia's 2017 estimated resident population for persons above 18 years of age is 7,467,887. Using the CMHS prevalence estimate of 5.4%, Georgia has an estimated 403,266 adults with SMI. In FY17, DBHDD served 122,183 consumers with SMI which was 30.3% of the overall need. Prevalence data has always been limited as a true measure of effectiveness of access and outreach efforts since consumers with benefits have access to services other than those provided by DBHDD. This is further complicated by the fact that the DBHDD now provides benefits only to those adults with no other funding source and to those receiving Medicaid benefits through the Aged, Blind and Disabled program. Other consumers living with serious mental illness may be served through Care Management Organizations (CMOs); thus, analysis of how many persons should be served through DBHDD is less clear than in previous years. Given this, DBHDD targets those adults 18 and over under 200% of poverty. The estimated number of adult consumers who need services from the public sector using this factor is 134,683 (33.4%). The percent of estimated eligible mental health need reached was 90.7%.
According to the 2018 Georgia URS Tables, DBHDD served 137,169 individuals in all Mental Health Programs. Of this number, 89% were adults ages 18 years and over. For all adults served, 11% were young adults ages 18-24 years old; 74% were adults ages 25-64 years old; 3% were older adults ages 65-74; and .5% adults over 75 years old. The breakdown of those served by race/ethnicity is; 50% were White; 43% were Black or African American; 4% were Hispanic or Latino; 1.4% were Asian; .2% were American Indian or Alaska Native; .2% were Native Hawaiian or Another Pacific Islander; and, 1.4% reported more than one race.

The data by gender indicates that 51.3% females (52.4%) and 48.7%) males were served.

In FY18, 137,169 consumers were served in the community representing 97% of all those served. In FY18, 3,576 adults were served in State Operated Psychiatric Hospitals compared to 4,309 in FY16. This represents a decrease of adults served in State Operated Psychiatric Hospitals. In FY16, the readmission rates for civil and voluntary admissions were 7.2% and 18.6% for 30 day and 180-day readmissions respectively. In FY18, the readmission rates for civil and voluntary admissions were 4.1% and 14.4% for 30 day and 180-day readmissions respectively, a considerable decrease.

Data gathered from the Information System indicate that 108,406 adults received Core Services in SFY19, 13,387 received Crisis Stabilization Unit services; 3,330 received Peer Support services; 1,652 received Psychosocial Rehabilitation group services; 3,049 received Supported Employment; and 2,529 received Assertive Community Treatment.

DBHDD utilizes a definition to identify adults who are eligible to receive public sector mental health services. This definition incorporates the elements of the federal definition for SMI and also sets diagnostic and functional criteria to identify eligibility for brief intervention for individuals who do not necessarily meet the SMI definition. "Priority Populations" define the individuals who are to be served with the public benefit.

There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services:

1. **Age:** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.
2. **Diagnostic Evaluation:** The DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. This includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.
4. **Financial Eligibility:** Established in DBHDD policy: The following individuals receive priority for ongoing treatment and support services:

   a. Individuals transitioning into the community from a state operated psychiatric facility (including forensic individuals), state funded/paid inpatient services, a crisis stabilization unit, behavioral health crisis center or intensive residential program.
   b. Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
   c. Individuals with a history of one or more crisis stabilization unit/behavioral health crisis center admissions within the past 3 years;
   d. Individuals with behavioral health needs who are criminal justice system involved, including those who are; court ordered to receive behavioral health services, under the correctional community supervision with mental illness or substance use disorder or dependence, released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;

e. Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
f. Individuals who are chronically homeless with behavioral health needs

Data to support planning and to monitor service effectiveness is collected through several processes. The contracted ERO collects and reports consumer encounter data that includes information on consumer level of need and response to treatment. When originally developed, this ERO data was only generated for Medicaid eligible consumers, which represents approximately half of the adults served in the public mental health system. Under the existing ERO contract this data is collected and reported for all consumers in service within the public mental health system, regardless of payer source. System evaluation information is collected with consumer surveys and clinical functional assessment tools. The consumer survey that is employed is administered consumer-to-consumer and utilizes the questions of the national MHSIP survey. The clinical functional assessment data is collected through the ERO function.

As indicated previously, the DBHDD system of services is administered through six Field Offices. These offices administer the hospital and community resources assigned to the region. They oversee statewide initiatives; develop new services and expand existing services as needed; and, monitor the services being received by consumers to ensure quality and access. Service planning is unique to the needs of each community and includes significant input from community members and service recipients. These offices have established Regional Collaboratives in their regions with representatives from provider agencies, advocacy groups, and other key stakeholders. These RCCs provide valuable information to the Field Offices related to service delivery. In addition, the Field Offices work collaboratively with established Regional Advisory Councils. These Councils are composed of community citizens appointed by their county Commissioners. Additional data on gaps and services by DBHDD Regions has been reported in the 2017-2018 DBHDD Statewide and Regional Priorities and Key Strategies document developed by the DBHDD Statewide Leadership Council which is composed of the Chairs of the 6 Regional Advisory Councils along with the entire RAC membership. The recommendations in the report are the result of a 20- month comprehensive community input and priority process conducted across the state and within each region. Below is demographic information on each region as well as information gathered through the RAC process above.

Region One

Region One's 31 counties span the width of North Georgia and have a total estimated adult population of 1,910,229 people representing 26.2% of the total adult population. Based on Federal
Center for Mental Health Services (CMHS) estimating methodology of 5.4% of the total adult population having a serious mental illness (SMI), there are approximately 103,152 adults with SMI. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 32,699 adults with SMI could be considered public sector consumers. In FY 16, DBHDD adult mental health contracted providers for Region 1 delivered one or more services to 24,076 individuals needing public sector services representing 73.6% of the need reached.

The Adult Core Services Package is provided under contract by five Community Service Boards (CSBs), now called Tier 1, Comprehensive Community Providers (CCPs) or Safety Net providers, one County Board of Health, and by one private provider (now both called Tier 2 plus). There are an additional 9 Tier 2 or Community Medicaid Providers (CMPs), approved to provide Adult Core services in Region 1. These providers may bill Medicaid or private insurance, but do not receive any state funds. In addition, there are 8 Tier 3 Providers, which are Specialty providers. Some of the services other than core services (traditional outpatient) provided by Region 1 providers are: Peer Supports, Peer Recovery Center, Specialty Courts, Community Support Team (CST), Case Management, ACT, Crisis Respite Apartments, Intensive Case Management, Supported Employment, Behavioral Health Crisis Center, Crisis Stabilization Unit, Crisis/Transitional Housing, Mobile Crisis, Inpatient Psychiatric Services, PATH, Supported Housing and Community Residential Rehabilitation. In SFY16, 22,521 individuals received core services; 1,563 received crisis stabilization unit services; 794 received peer support services; 98 received psychosocial rehabilitation group services; 392 individuals received supported employment services; and, 446 individuals received ACT services.

Some of the priority needs and key strategies related to adult mental health for Region 1 recommended in the 2017-2018 RAC Report are:

- Reduce inappropriate involvement in the justice system by persons with mental illness, intellectual/developmental disabilities, and/or substance abuse.
    - Training for first responders to improve responses to people in crisis
    - Reduce recidivism rates through accountability courts
- Increase availability and enhance residential care for individuals with intellectual/developmental disabilities, mental illness, and or addictive diseases which would foster safe, comfortable home environments.
- Review and revise standards for staffing credentials and improve training to better meet the needs of individuals served.
- Improve access to and navigation of DBHDD services.
- Improve public understanding of the system and how to engage in services.
- Increase availability of peer supports to help people stay engaged in services.

Region Two

Region 2 is comprised of 33 counties covering 12,214 square miles with a total estimated adult population of 939,417 representing 12.9% of the total adult population in the state. Based on Federal Center for Mental Health Services (CMHS) estimating methodology of 5.4% of the total adult population having a serious mental illness (SMI), there are an estimated 50,729 adults with SMI. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 20,088 adults with SMI could be considered public sector consumers. In FY16, DBHDD adult mental health contracted providers for Region 2 delivered one or more services to 21,207 individuals needing public sector services representing 105.6% of the need.

The adult core services package is provided under contract by 5 Tier 1 providers (CCPs) receiving state funding to serve adults with behavioral health needs. There are also 8 Tier 2 providers (CMPs) and 7 Tier 3 Specialty providers. In addition to Core Services, there are other

services available: Case Management, Intensive Case Management, Community Support Team, ACT, Psychosocial Rehabilitation, Peer Support, Supported Employment, Crisis Stabilization Unit, Crisis Service Center, Crisis Respite Apartments, Mobile Crisis, Inpatient Psychiatric Services, Supported Housing and Community Residential Rehabilitation, PATH, and MH courts. In SFY16, 20,778 individuals received core services; 1,625 received crisis stabilization unit services; 415 received peer support services; 150 received psychosocial rehabilitation group services; 471 received supported employment services; and, 382 received ACT services.

Some of the priority needs and key strategies related to adult mental health for Region 2 recommended in the 2017-2018 RAC Report are:

- ❖ Establish a quality provider for Intellectual/Developmental Disabilities /Behavioral Health dual diagnosis including emergency and long-term residential services.
- ➢ Identify an evidence-based dual diagnosis treatment model
- ➢ Incentivize providers who are capable and interested
- ➢ Provide training for sustainability
- ➢ Identify funding sources
- ❖ Improve coordination among state agencies including Department of Family and Children's Services, Social Security, Department of Aging, and DBHDD.
- ➢ Identify which state agencies work with the target population.
- ➢ Create memoranda of understanding between state departments
- ➢ Create work groups to create solutions to barriers.
- ➢ Educate the public on desired outcomes
- ❖ Develop a comprehensive data management system that identifies current provider availability along with current placement needs.
- ➢ Identify current providers and capacity.
- ➢ Use Beacon system to identify how many individuals are being served in various programs
- ➢ Create a triage system
- ➢ Create a communication map of services delivered by each provider and provide to key stakeholders

Region Three

Region 3 is comprised of six metropolitan counties: Clayton, DeKalb, Fulton, Gwinnett, Newton and Rockdale and includes the capitol city of Atlanta. The total adult population of the region is 2,197,961 representing 30% of the adult population in the state. Using prevalence data, the number of adults with serious mental illness estimated to need treatment, residing in Region 3 is 118,690, or 5.4% of the total adult population. During FY16, 26,512 adults received behavioral health services from the provider network in Region 3. This number represents 23.3% of the estimated total need without factoring in eligibility for public sector services. Factoring in poverty, the estimated number needing services would be 39,168 representing 67.7% of the need reached.

There are 89 providers: 3 Tier 1 (CCPs), 54 Tier 2 (CMPs), 5 Tier 2+ and 27 Tier 3 Specialty providers. Services provided are Core, Case Management, ACT, ICM, Supported Housing and Community Residential Rehabilitation, Supported Employment, Crisis Respite Apartments,

Behavioral Health Crisis Center, Crisis Stabilization Unit, Mobile Crisis, Peer Support and Wellness, PATH, and MH Treatment Court Services. In addition, Region 3 is home to a provider for the Latino population, CETPA. In SFY16, 24,023 individuals received core services; 1,285 individuals received crisis stabilization unit services; 854 received peer support services; 734 received psychosocial rehabilitation group services; 467 received supported employment services; and 1,216 received ACT services.

The priority needs and key strategies related to adult mental health for Region 3 recommended in the 2017-2018 RAC Report are:

- Increase community awareness of DBHDD diagnosis and treatment services.
- Improve collaboration, communication, and education among all facets of the Criminal Justice Systems.

Region Four

Region 4 is comprised of 24 counties and is in the far Southwest corner of Georgia, bordering Southeast Alabama and North Florida. Region 4 is the smallest of the 6 Regions; however, the geographic area is 9,320 square miles, most of which is rural. The adult population is 438,911 representing 6% of the total adult population. Based on CMHS prevalence estimates, there are 23,701 adults with SMI in the region. Providers in this region served 13,511 adults with SMI. This number represents 57% of the estimated total need without factoring in eligibility for public sector services. Factoring in poverty, the estimated number needing services would be 11,258 representing 120% of the need reached.

The Behavioral Health system is comprised of 3 Tier 1 providers (CCPs), 3 Tier 2 providers (CMPs) and 6 Tier 3 Specialty providers. The services provided include: Core, Assertive Community Treatment, Case Management, Community Inpatient/Detox, Community Support Team, Behavioral Health Crisis Centers, Crisis Respite Apartments, Supported Housing and Community Residential Rehabilitation, Intensive Case Management, Peer Supports, Psychosocial Rehabilitation, and Supported Employment. In SFY16, 13,167 individuals received core services; 1,361 received crisis stabilization unit services; 332 received peer support services; 163 received psychosocial rehabilitation services group; 283 received supported employment services; and, 365 received ACT services.

The priority needs and key strategies related to adult mental health for Region 4 recommended in the 2017-2018 RAC Report are:

- Improve the ease of access to outpatient treatment for behavioral health, addictive diseases, and intellectual developmental disabilities in rural areas.
- Fund and recruit professional counselors to assess and treat individuals
- Collect data for everyone served to include distance traveled, costs of reaching destination and rate convenience of service location

Region Five

Region 5 is in the southeast corner of Georgia; it has a land mass of 15,128 square miles and covers 26% of the state. The region includes 34 counties. Overall population density for the region is significantly smaller than the density of the State of Georgia. The adult population is 791,140, representing 10%

of the total adult population in the state. Based on prevalence estimates, there are 42,722 adults in the region with SMI. During FY 2016, the number of adult consumers with SMI served in the region was 15,862, representing 37.1% of the need. Factoring in poverty, the estimated number needing services would be 17,089 representing 92.8% of the need reached.

In Region 5 there are 4 Tier 1 providers (CCPs), 3 Tier 2 providers (CMPs), 1 Tier 2+ provider, and 5 Tier 3 Specialty providers. They provide core services, Assertive Community Treatment, Community Support Team, Case Management, Intensive Case Management, Mobile Crisis, Crisis Respite Apartments, Crisis Stabilization Units, Inpatient Psychiatric Services, Supported Housing and Community Residential Rehabilitation PATH and a specialized jail diversion program. In SFY16, 15,806 individuals received core services; 1,676 received crisis stabilization unit services; 556 received peer support services; 418 received psychosocial rehabilitation group services; 356 received supported employment services; and, 406 received ACT services.

The priority needs and key strategies related to adult mental health for Region 5 recommended in the 2017-2018 RAC Report are:

- Increase overall funding at state level for DBHDD services in Georgia.
- Launch campaigns to educate legislators about public mental health services and the need for increased funding to provide these services.
- Encourage Community Service Boards to meet with local elected officials in their catchment areas to work collaboratively and creatively to use local resources to meet needs.
- Address the need for additional crisis beds including crisis stabilization units and crisis respite apartments.
- Secure a new Behavioral Health Crisis Center.
- Investigate evidence-based treatment programs to reduce likelihood of re-hospitalization.
- Investigate structure treatment programs such as Clubhouse programs and supported employment programs.

Region Six

Region 6 ranks third in population among the six DBHDD regions and covers 9,822 square miles. Many residents live in rural areas. The total adult population is 1,000,777, which represents 13.7% of the total adult population in the state. Based on CMHS prevalence estimates, there are 54,042 adults with SMI. The number of adults served in the region by DBHDD providers was 17,603, representing 32.6% of the need. Factoring in poverty, the estimated number needing services would be 18,212 representing 96.7%% of the need reached.

In Region 6 there are 5 Tier 1 providers (CCPs), 8 Tier 2 providers (CMPs) and 5 Tier 3 Specialty providers. The services provided are Core Services, Community Support Team, Case Management, Crisis Respite Apartments, Psychosocial Rehabilitation, Peer Support, Supported Employment, Case Management and Intensive Case Management, ACT, Behavioral Health Crisis Center, CSU, Mobile Crisis, Inpatient Psychiatric Services, Supported Housing and Community Residential Rehabilitation. In SFY16, 15,026 individuals received core services; 903 received crisis stabilization unit services; 493 received peer support services; 363 received psychosocial rehabilitation group services; 413 received supported employment services; and,

300 received ACT services.

The priority needs and key strategies related to adult mental health for Region Six recommended in the 2017-2018 RAC Report are:

- Address critical staffing shortages and the need for specialty services by recruiting providers and expanding telemedicine, mobile medicine, and crisis intervention services
- Work with Community Service Boards and other providers to identify and assess critical staff shortages
- Share this information with key stakeholders
- Work with CSBs to identify and initiate creative recruitment such as partnering with colleges and nursing schools
- Address shortages in rural areas through telemedicine, mobile medicine and crisis intervention services.

ADULT MENTAL HEALTH-PLANS TO ADDRESS UNMET NEEDS

Based on information from the analysis of available data sources, Regional Advisory Councils recommendations, input from the Behavioral Health Planning and Advisory Council, and the overall strategic direction of the DBHDD, the following areas will be addressed in the 2018-2019 MHBG application.

Increase Permanent Supported Housing

As part of Georgia's agreement with the Department of Justice under the Americans with Disabilities Act, DBHDD operates a housing voucher program targeting persons with serious and persistent mental illness transitioning out of institutional settings and those who are chronically homeless. Georgia has now entered a Settlement Agreement Extension which includes requirements for Supported Housing. The Agreement Extension, which was signed in the fall of 2016 is scheduled to end 6/30/18. In response to the Settlement Agreement the Department implemented the Need for Supporting Housing Survey (NSH) to assess the need for supported housing for individuals meeting DOJ settlement criteria. Between May 2016 and August 8, 2017, 1,107 individuals have been surveyed, of that number, 48% (529) individuals were determined to need supported housing. DBHDD is currently partnering with state and local re-reentry initiatives to ensure that those with serious mental health needs being released from jails/prisons have access to community-based services and supported housing.

In FY08, the Department of Community Affairs (DCA) and DBHDD entered a partnership to expand the housing resources for homeless individuals and those with behavioral health disabilities. The two Departments have been working cooperatively to establish supported housing programs and assist eligible individuals in obtaining and maintaining safe, affordable, independent housing. DCA provides many financing programs to develop housing and DBHDD provides the services and supports needed to assist people in remaining in the communities of choice. DBHDD continues to strengthen partnerships that can increase the availability of permanent supported housing for those with serious mental illness who are homeless.

In FY 2017, DBHDD and DCA expanded their MOU and created a shared position, the Director of Supported Housing, to cooperatively advance the collective housing efforts of both agencies. In March of 2017, the Office of Adult Mental Health, created the Supported Housing Unit with three staff dedicated and under the direction of the Supported Housing Director. This unit will move forth the goals of supporting providers of both housing and residential services as well as meeting and sustaining the supported housing requirements of the Settlement Agreement Extension. This includes, increasing access to supported housing for our target population, maximizing state resources for supported housing for our target population, operationalizing a statewide unified referral process for supported housing, and continuing the work of oversight of the statewide supported housing need and choice survey. This unit will work in collaboration with the DBHDD and DCA regional field offices, community BH providers, hospitals, state and local agencies and law enforcement to support comprehensive implementation of strategies that will promote supported housing access statewide.

Housing has been identified as a needed resource in all the DBHDD regions. Under the Settlement Agreement, DBHDD is required to provide expanded and enhanced community services of which supported housing is one. DBHDD has housing as a priority with a focus on supporting recovery of adults in community settings. Tier 1 providers operate under 12 CCP Standards and these standards include access to housing. The FY20 MHBG application includes Permanent Supported Housing as a priority area.

Increase Employment

Employment is a significant recovery support. DBHDD contracts for Supported Employment (SE) statewide. In past years, because of significant increases in state and MHBG funding, DBHDD has increased the SE service capacity in recent years. In addition, the department has continued to implement provider training on evidence-based practice SE (EBP SE) also known as the Individual Placement & Support (IPS) Model.

DBHDD has continued working with the Georgia Vocational Rehabilitation Agency (GVRA), Vocational Rehabilitation program (VR) formerly with the GA Department of Labor. In May 2015, a revised MOU was signed by agency Commissioners to formalize the partnership and agreement to work in a more coordinated and efficient manner, in accordance with federal and state regulations to provide EBP SE services and support more individuals with SPMI in meeting their vocational and employment goals. DBHDD and GVRA/VR Regional and State Office staff have implemented the recommendations to amend and create policies and procedures that will facilitate fulfillment of these goals.

DBHDD has established a priority to increase the number of adults with SMI to obtain and maintain employment. DBHDD collects data on employment in competitive employment settings. The FY20 MHBG application includes a priority focus on obtaining and maintaining employment.

Increase Access to Services for Adults Involved with Criminal Justice

In 2013, the BHCC established an initiative to address the needs of persons transitioning from the correctional/justice system into the community and created a workgroup, co-chaired by the DBHDD Director of Adult Mental Health and the Department of Community Supervision

Reentry Director to examine the issues. Early outcomes are fostering inter-agency partnerships to address barriers and infrastructure challenges for persons in the criminal justice system. From this collaboration developed the Forensic Peer Mentor initiative which focuses on successful transition of persons with behavioral health needs from incarceration back into the community. DBHDD is involved in the Georgia Prison Reentry Initiative (GPRI). This collaboration brings partnering agencies together to address issues of service access and effective community transition for persons with a mental illness who are returning from the correctional system.

DBHDD has established a priority to increase access to behavioral health services for returning citizens/criminal justice involved individuals with behavioral health needs. The FY20 MHBG application includes a priority focus on this population including the provision of forensic peer services, family reunification counseling and Peer Support services, as well as referrals of the target population to community mental health services.

Increase Access to Services for Older Adults

In July 2014, DBHDD and the Division of Aging Services (DAS) entered an agreement with the Fuqua Center for Late-Life Depression, Emory University to strengthen Georgia's system of care for the growing older adult population with severe and persistent mental illnesses. Work guided by the MOU includes identification of unmet needs of this population and the development of applicable processes aimed at improving the state's capacity to care for Older Adults with Mental Illness. In FY18 this agreement has been extended to include The Carter Center. A staff member from DBHDD and DAS have time committed to this work.

DBHDD also participates in the Georgia Coalition on Older Adults and Behavioral Health (GCOABH). The GCOABH has led efforts to cross train the aging network and the public behavioral health system regarding both systems of care and how to access services.

DBHDD has developed priority areas and indicators to focus on older adults in this MHBG application. The focus will be to increase access to community mental health services for adults with SMI who are age 65 or older as well as provision of cross training for behavioral health providers.

Increase Access to Deaf Mental Health Services

It is Georgia's vision that all individuals, including individuals who are deaf, deaf-blind, or hard of hearing and utilize ASL as a preferred language, have easy access to linguistically accessible and culturally competent high-quality care that leads to a life of recovery and independence. To this end, DBHDD created the Office of Deaf Services (ODS). This office is working on the following priority areas:

- Identification of Individuals with Hearing Loss.
- Identification of Communication Preferences and Needs
- Workforce Development of Georgia Behavioral Health Interpreters (GaBHIs)
- Development of Statewide Community-Based Accessible Services
- Deaf Services Provider Training Series
- Promotion of Public Information Awareness and Community Outreach

DBHDD is committed to developing and implementing Communication Assessment Reports to support generally accepted professional standards regarding provision of reasonable accommodations to DBHDD services for individuals who are deaf. These standards include identifying reasonable accommodations needed to access DBHDD services. The Communication Assessment Report provides a determination of any communication limitations and the reasonable accommodations needed for the individual to access DBHDD services in accordance with the Americans with Disabilities Act. In addition, the 2014 Belton Consent Order requires Communication Assessments to be completed for Deaf Class Members in connection with their entering non-crisis services. Deaf Class Members are defined in the order as individuals identified as deaf, receiving state or (non-MCO) Medicaid funding, and receiving non-crisis outpatient therapy services.

To identify and track appropriate provision of reasonable accommodations to services and to maintain compliance with the Belton Consent Order, it is essential that the Office of Deaf Services completes a Communication Assessment Report on all individuals identified as deaf and receiving state or (non-MCO) Medicaid funding to determine the individual communication accommodations needed.

To support this priority area DBHDD ODS has implemented several strategies including but not limited to:

- Infrastructure development:
  - Development of a Deaf Services Management System to track individuals who are deaf and receiving DBHDD services.
  - Hiring and training three additional Communication Assessment Specialists.
- Systemic development
  - Publication of Policy 15-111: Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, which obligates providers to report individuals who are deaf to the Office of Deaf Services to complete a Communication Assessment prior to intake where possible.
  - Publication of Policy 15-112: Communication Assessment-development of a communication assessment report to document communication preferences and service accommodation needs.
- Provider Education
  - Publication of Policy 15-114: Accessibility of Community Behavioral Health Services for Individuals who are Deaf and hard of Hearing
  - Mandatory Behavioral Health provider trainings on Policy 15-111, Policy 15-112, Policy 15-114 and ADA requirements as well as portions of the provider contract and provider manual that pertain to individuals who are deaf.
  - Deaf Specific Crisis training developed for crisis providers across the state.
  - Mandatory Deaf Services Awareness Training for community behavioral health providers (counselors, therapists, social workers, and case managers, those support professionals who schedule appointments) to better equip providers to deal with individuals who have a mental health need and who may seek to receive community behavioral health services.